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ABSTRACT

Reported are the proceedings of a three-week conference for special education administrators working with educational programs for the institutionalized mentally handicapped. Conference papers included are: The Role of a Residential Facility in Modern Society, by Robert Dentler; The Present Nature of Residential Populations, by Harvey Dingman: Multidimensional Problems of Administration in a Residential Setting, by Harvey Stevens; and The Current Status of Education in Residential Centers in the U.S. by Wesley White. Also presented are The Educational Roles of a Residential Center, by David Rosen; Assessment and Placement, by Margaret Jo Shepherd; Administrative Implications for Education at Various Ability Levels, by Robert Erdman; Resources for Implementing the Administrative Model, by Philip Roos; and An Administrative Model for the Residential Setting - An Application of Open System Theory, by Arthur Lewis. Appended are a summary of group problems, reactions to problem solving, and a list of conference participants. (KW)

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SPECIAL EDUCATION in the RESIDENTIAL SETTING

Proceedings

June 30 - July 18, 1969

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Columbia University

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SPECIAL EDUCATION ADMINISTRATION IN THE RESIDENTIAL SETTING

Institute Co-Directors and Editors:

William J. Younie, Ed.D.
Associate Professor
Department of Special Education
Coordinator, Programs in Special Education Administration

I. Ignacy Goldberg, Ed.D.
Professor of Education
Department of Special Education
Coordinator, Programs in Mental Retardation

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
OFFICE OF EDUCATION

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in the

RESIDENTIAL SETTING

Proceedings

Special Study Institute

June 30 - July 18, 1969

Division for Handicapped Children
Office of Education
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Department of Special Education
Teachers College
Columbia University

Special Education Administration in the Residential Setting

Proceedings at a conference held June 30 to July 18, 1969 at Teachers College, Columbia University*

Table of Contents

William J. Younie, I. Ignacy Goldberg--Introduction

I. Robert Dentler
"The Role of a Residential Facility in Modern Society" P. 1

II. Harvey Dingman
"The Present Nature of Residential Populations" P. 11

III. Harvey Stevens
"Multidimensional Problems of Administration in a Residential Setting" P. 34

IV. Wesley White
"The Current Status of Education in Residential Centers in the United States" P. 42

V. David Rosen
"The Educational Roles of a Residential Center" P. 57

VI. Margaret Jo Shepherd
"Assessment and Placement" P. 77

VII. Robert Erdman
"Administrative Implications for Education at Various Ability Levels" P. 93

VIII. Philip Roos
"Resources for Implementing the Administrative Model" P. 112

IX. Arthur Lewis
"An Administrative Model for the Residential Setting: An Application of Open System Theory" P. 141

Appendix A Summary of Group Problems

Appendix B Reactions to Problem Solving

Appendix C List of Conference Participants

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U. S. Office of Education

Introduction

The three-week conference for special education administrators working in residential settings, the proceedings of which are recorded in this publication, was designed to bring together practitioners and theorists for the purpose of delineating a rather neglected educational area. To our knowledge, this effort was the first systematic attempt to establish a dialogue on residential educational problems among a group of professional educators charged with designing and operating educational programs for institutionalized retardates. Conference invitations were limited to ten northeastern states in order to provide some geographic and philosophical cohesiveness. Twenty-six participants from nine of these states attended and provided a quick refutation to all preconceived notions about their supposed geographic and philosophical similarity. The conference employed a number of recognized authorities in the fields of mental retardation, residential care, special education, and general administration to present ideas which were followed up by the group in free discussion, structured discussion, and simulation sessions. Other conference activities included visits to residential facilities that represent emerging patterns of institutional care, a visual aids workshop provided by the participants, and the viewing of several popularly distributed films that related to the topics of the conference (Charly-Titticut Follies).

In addition to the information which will be given to the reader by the following conference papers and discussion summaries, he should also be aware of the following conclusions which were reached after a careful evaluation of the participants and their conference activities.

1. The conference met an obviously real need of the participants and their sending institutions for an opportunity to discuss and try to solve mutual problems. Apparently, this need is not being met by professional organizations or any other facilitating agency in the States or in the area represented by the group. The participants were very clear in their insistence that some means must be found to continue the dialogue stimulated by the conference. No concrete steps to formalize such continuation were agreed upon but certainly the readiness for such activity should be seen as a stimulus bu professional groups and governmental agencies to sponsor regular meetings of residential educational administrators, both as a group and as a partnership with public school special educators, and those residentially oriented professional groups with which the institutional educator must interact.

2. It was very vividly indicated by the conferee's statements that it is a grave mistake to generalize about the programs, problems, and progress of residential education. Each institution appears to stand alone in its willingness, effectiveness, and ability to provide

adequate or superior instructional services. Perhaps, there is need to set and apply certain standards but such activity would seem to have little basis in reality unless it is based solidly on a knowledge and appreciation of individual problems.

3. The conference staff and speakers were continually impressed by the quality of thinking and the high degree of leadership expressed by the participants. Perhaps only the best are sent to institutes of this sort. Or, perhaps it is time to re-evaluate the stereotype of the institutionalized professional as someone who primarily seeks security and fears upsetting the status-quo. The conference group offers a professional resource to its collective community and the professional organizations contained therin that obviously is only partially topped. The conference suggests a great need on the part of special educators generally to look much more closely at their residentially based memberships and to welcome them to the mainstream to which they so deservedly belong.

4. In addition to the needs cited above, there is another area that must be studied very quickly. This focus is the entire problem of how to train residential special educators. It is obvious from the facts revealed by this conference that the institutional administrator requires specialized education that is not now available to him. The content and context of such a potential program is rather clear. It is the interest and support for such an endeavor that is lacking. A clear field awaits the creative college or university that is willing to undertake such a sorely needed program.

These comments have attempted to outline some of the ideas for present and future study suggested by the conference participants. It is obvious that these ideas are only fragmentory and must be filled out. It is hoped that the reader will achieve realization of such expansion through the materials that follow.

I

The Role of a Residential Facility in Modern Society

Dr. Robert Dentler

The studies of Jules Henry, Bruno Bettleheim, and Erving Goffman, among others, have opened to question in recent years the extent to which American national culture prescribes within its vast mosaic a hospitable place for children. And, those of us who have concentrated for the past decade upon studies of the nature of urban public education of the children of the poor can do little more than echo this question.

Since 1930, the merits of institutionalized care of children have received hyper-critical examination in the United States. The fruits of this examination include a revolution in vital aspects of institutional policy and practice -- as to who was remaned, how diagnoses were made, how treatment was designed, and above all in how such activities as teaching and recreation were to be carried on together with non-normal care-linked activities. The revolution reversed practices in the processing of orphaned children; it transformed the public conception of mental retardation; and it generated a host of new medical and educative crafts capable of really helping to reduce the burdens imposed by disabilities. Progress has been so stunning that to professional personnel within institutions, these seem like times of hope and gratification. There have been great positive changes. As I treat of dilemmas and failures, keep this in mind or you will not see why I conclude with three notes of optimism.

Meanwhile, the worst suspicions of those inside treatment institutions about the realities of life outside have begun to be affirmed. I remember visiting

Dr. Mortimer Kreuter's outstandingly effective high school for boys imprisoned as criminal delinquents on Ryker's Island in the Bronx in 1963. After witnessing successful programs in academic preparatory studies, automotive repair, baking, botany and gardening, and music, I inquired about the success rate of graduates in the outside world. "Oh, running this school is a challenge because success on the outside is impossible," said Dr. Kreuter. "Not one in a hundred graduates will get a chance at a job, no matter how well educated he has become, and 80 or so out of 100 will be back in prison within two years after getting out of here. Our school is like a hair shirt," he said, "It never stops itching the staff. We have to find motivating forces in spite of a fairly hopeless life situation. If you can educate under these conditions, you know you are doing something." And, of course, the conditions he referred to were those common to the outside, not the prison.

It is the community at large that is most often opposed to half-way houses, work-study program, shared facilities, and often to mixing of any kind. It is this community, acting out very ancient cultural prescriptions, that prefers institutional isolation, remoteness, budgetary starvation, and harsh modes of institutional care.

It is sociologically very doubtful to assume that those who run or those who inhabit institutions can do very much to transform the surrounding culture. I believe that Emile Burkheim was right in postulating that educational institutions, among others, are refracted versions of the society that creates and maintains them. Thus, I agree with the indictment that institutional psychologists Steve Pratt and Jay Tooley make against American mental

hospitals, and I invite you to apply it to closed (that is residential treatment) institutions for retarded, disturbed, disabled, or delinquent children:

> A vast network of prisons stretches across our country supplemented by a secondary network of some 500 eleemosynary establishments quaintly mislabeled 'hospitals-of-the-mind,' in which thousands of citizens, close to a million on any given day, mislabed 'mentally ill', are incarcerated. With just a touch of tautology but quite operationally, many researchers define what they label 'mental illness' as the state of being 'hospitalized' in what they metaphorically call a 'mental hospital'. These establishments from the societal level serve neither much nor well their hapless inmates, but certainly serve with drastic 'effectiveness' their <u>true clients</u> -- the social agencies and gatekeepers of control, correction, and 'benevolence' -- those who have need to put troublesome people away.

One more lengthy quotation seems to me to be in order, for Pratt and Tooley summarize most trenchantly, it seems to me, the argument against closed treatment institutions in American:

> This system is ideal for maintaining an absolute class hierarchy of staff subordination and beneath that of inmate subordination. Spontaneity, self-actualization, democratic peer group process, emergent leadership or inmate or staff -- these prerequisites of a corrective transactional program are effectively precluded. Bureaucratic structure inappropriately transforms secondary institutional goals of plant efficiency into primary goals. Plant efficiency as an end in itself is incongruent with proclaimed goals mislabeled 'treatment' or 'cure,' and antagonistic to appropriate goals of psychosocial actualization through client-client, client-staff, clienty-community transactions. Vested interests shore up the <u>status quo</u> and desperately postpone radical change.

> ... It may be the only structure available in this socioeconomic culture to provide the naked and concealed power arrangements, and authority-derived-from-professional-position, necessary to perpetrate ... such preposterous operations... Sanctioned by master-symbols and public mandate, professional vested interests interlock with society's need for segregation and incarceration of troublesome people -- all popularized and sanctified via propaganda of the mislabeled 'mental health' movement ...

I agree with Pratt and Tooley, except that I believe their anger is partially misdirected because of their own long participation in the profession of institutional care. They are aware of cultural context, but their anger focuses too heavily upon the faults inherent within institutional practice.

In short, I believe the case against the closed institution was easier to make ten years and earlier than it is today, for two reasons. First, we have begun to get a clearer social vision of the nature of "life on the outside." Second, relative to those who treat and educate on the outside, the institutionalists begin to sound more impressive. They criticize themselves more openly sometimes and they make more vigorous attempts to change than do city school teachers, or university professors, or neighborhood general practitioners.

The relative view and the shift in the angle of vision are both improved, what is more, when we attend specifically to the way in which the children of the minority poor are treated in our society. This, after all, is the proper test, for these are the children whose reception reveals to us the measure of humanity appropriate to any civilization. And, these are the children whose

needs stand in relief upon the doorsteps of both the community at large and the closed institution. When the Governor of South Carolina undergoes a psychic revelation and acknowledges publically that some citizens of his state are indeed starving, we should not be surprised that our view of life within treatment institutions becomes less harsh.

The practices that institutionalists have been inventing and testing since World War II, moreover, sound like a roster of the practices that are only now beginning to permeate the dialogue around public education and outpatient hospital care. Sensitivity training, staff orientation programs in human relations, extension of the life of the client into the community and importation of agents of the community into the institution, are examples of efforts at effective change that are increasingly commonplace in closed institutions but are just now being introduced very tentatively into normal public schools and hospitals.

Experience gained by special educationists is still not being transmitted into general public education to any important extent. The boundaries between the bureaus and divisions in our state departments and within the U. S. Office of Education are firm. The special educationists, after years of indifference from the public and avoidance among the professions, have built up protective walls that prevent their discoveries from influencing policy and practice on the outside. And the few who send relevant messages are seldom well received.

The boundaries are maintained, too, by preservation of the mythology of special regimens. The myth that instructional approaches must be tailored

elaborately around each diagnostic category of learner encourages the proliferation of professions but reduces the transfer of knowledge about pedagogy.

Yet, when these boundaries begin to crumble, I suspect they will crumble from the outside in, as the non-institutionalists discover that productive educational programming has been developed within special education.

The basic case against closed institutions cannot be transcended in the case of children. The costs to effective socialization borne by virtue of a closed institution's diagnostic, staff and ethnic and class segregation; the bureaucratic routinization of daily life; the impersonality of sequestered massing; and the participation in rituals of symbolic degradation and degrouping; these are costs that work against the prospects of cognitive and affective growth.

Still, imaginable alternatives continue to remain far from implementation, and in the meanwhile, much can be accomplished by emphasizing the quest for optimum care, treatment, and education. The alternatives should be shaped through task forces mobilized by special educators and their associates in closed institutions. Unless this comes to be true, much of educative and therapeutic value may be lost in the transition from closed institutions to an open society. But this may be wishful thinking, given the character of vestment of interest both within institutional staffs and from the outside, feeder agencies.

All of this has been by way of backdrop to addressing the question: what is of potential value in the closed institution and how may that potential be realized?

1. Some closed institutions are in a position to formulate and live out a coherent philosophy of human transactions. This has happened naturalistically time and again in the history of leadership in institutions for children with special disabilities: an outstanding person creates or takes over the institution and transforms it by virtue of the power and clarity of his purposes. While we shall always gain from such moments, we are now capable of engineering an institutional milieu without benefit of charismatic inspiration.

Closed institutions can stand free of some of the disordered failures that attend pragmatic ecclecticism, while public schools and state universities, for example, cannot. Closed institutions can exploit their place in a zone of comparative indifference and ecological isolation in order to carry out great experiments in affecting lives. To some extent, closed institutions can even reverse the priorities the culture as a whole prescribes. They can choose to give much greater weight to values of esteem, respect, and attention, for example, and less to values of control, competition, and status. Few do this now, but the options are at hand.

2. Closed institutions serving children could intensify their struggle to delimit the nature of the clientele they are best equipped to serve. Conditions may have changed dramatically since 1959 when Donald Bloch and Majorie Behrens made their Report to the New York State Interdepartmental Health Resources Board on a Study of Children Referred for Residential Treatment in New York State, but I quote them nonetheless to identify the challenge:

> The number of children being referred for residential treatment...drops sharply at around the age of 13... The percept of the child changes drastically once he becomes adolescent, The same child under 13 is felt to be in need of residential treatment; at a later date he is perceived as a candidate for a training school. One is forced to recognize the unity of the 'placement', 'residential treatment', and 'delinquency' proglems, This is, of course, just a matter of a definition chasing its own tail. For the most part, there are no residential treatment centers for children over 13 or training schools for children under 13; so fewer children over 13 are referred to residential treatment centers and no children under 13 are referred to training schools. The point is that they are the same youngsters a few years older.

Yet, it is not as if the children studied by Bloch and Behrens were unidentified. As they report.

> Three-quarters of our cases were known to agency before they were 9 years old and one-half of them were known before they were six. These children and their families have been 'found' as cases early and often; they have been known to community agencies for a long time ... they have received a great deal of diagnostic service (an average of two diagnoses per case); they have received diagnostic, referral, and placement services and very little else in the way of treatment, such as casework, psychotherapy, or special educational arrangements... There is little evidence of coordination of services or of continuity of care.

Is it still true that each child entering a residential treatment institution carries behind him from three to five applications to that institution? This was the situation in 1969 in New York? Has the institutional reception average improved?

Again, ten years ago in Kansas, I found that state institutions for the mentally retarded could not stabilize their client entry rates and characteristics because of complicated, intense games that were being played around scarce resources at echelons in the state above the reach of institutional officers. Is this still the condition in our public treatment institutions, or have games of musical chairs and daisy chains of prestige surrounding control over admissions given way to the specification of institutional capabilities?

3. Finally, I would suggest that closed institutions might be in a position to <u>educate</u> the children they house. Lest this sound absurd to an assembly of special educators, let me make clear that we are overwhelmed with evidence in educational research conducted in non-institutional schools about the extent to which teaching is <u>not</u> productive of cognitive growth. The chief correlates of growth are life history antecedents of the learners. A gaping discontinuity obtains between the life of the teaching staff and the life of the student body, and instructional programs seldom aimed at reducing the discontinuity. The reasons for this are cultural, historical, and organizational.

All I want to assert is that some of these reasons may not be applicable to the situation of the closed institution. Instructional programs can <u>perhaps</u> be tailored to meet the learning requirements of child clients within residential institutions. The tailoring need not be slavishly preoccupied with diagnoses or syndromes. But it can, as it has been increasingly for 25 years, aim at relevant transaction with the child. The prospect is <u>less</u> sanguine in this regard in the non-special public school.

In turn, what educates special students will guide others to new interest in educating all children. This transfer is already occurring from Head-Start and other compensatory education programs into wealthy white ghetto schools. It can work for institutional educators, too.

II

The Present Nature of Residential Populations

Dr. Harvey F. Dingman

Introduction

One of the most obvious facts about an institution for the mentally retarded is its stability and resistance to change. The location was selected by the Legislature. The buildings were constructed by appropriated funds, and buildings are rarely replaced. The patients are often placed in an institution with the implicit understanding that they are being removed from the family for life. These are the facts that are self evident to every employee of the institution.

The employees learn to recognize the patients and their intellectual deformities. The employees then begin to construct a living society in which all can function. When buildings outlive their purpose they are remodeled for some other function or simply left empty until a program is developed that could use the buildings. Although new buildings are built and new patients are admitted and new programs are developed, they are viewed as supplementary or complementary---not as replacements for the old.

Since there are patterns or syndromes of behavior in the retarded, and since the retarded can easily be "grouped" on such factors as mental age, social skills, etc., the sheer number of retardates in any facility is easily managed by classifying them into the stereotypes that the staff develops for each group.

The arrival of a research worker can be most frustrating to an institutional staff. As he develops his research program he becomes aware of some of the dynamics of the institution. The patient population,

on which he depends for his subjects, keeps changing in subtle ways; the staff, on whom he relies for support of his research, changes rather quickly as the months roll by. The systematic remodeling of the wards (or cottages) produces a shifting population in any one building. An employee's view of stability may appear to be change to others; serenity sought by the Legislature for the "children" often seems like chaos to the research workers.

Definition of the Population

It would seem that the character of the resident population would be easily defined for any one day. The number of retardates can be established and a daily or weekly census of changes will need to be balanced by taking into account the number of escapes, the number on official leave, etc., however a number of problems remain. The identification of individual patients is often a matter of consensus of the staff. The characteristics of a patient, such as Dx, blindness, ethnic status, etc. are a matter of consensus among the relevant groups that have the responsibility for making that judgment. Often those who judge have little or no training to qualify them to make the judgments; nevertheless, decisions must be made. These judges then develop rules for deciding on Dx, whether a patient is epileptic, or whether he has behavior problems. After the decision is made, the individual is treated as if he were a member of that portion of patient society whether he really is or not. When there is an error in the judgment about a patient, the patient often learns to conform to his new category-state, since it is very difficult to alter an institutional decision.

After a patient has been identified and categorized, the nature of the population would seem to be easily defined. This is really not

so. Most of the patients who are resident at any point or time can be identified and categorized, i.e., "midnight census." How, in fact, are patients counted who are living in employee homes, are AWOL, in a hospital for the acutely ill, or are on leave with their families? Each set of rules for counting "the population" are different, and they produce different results.

Assuming that these problems can be surmounted, the tabulations can then begin. Many institutions have more than 200 categories of information for each patient. The decision on the categories to be tabulated depends on the reason for the study. The methods and extent of the tabulation depend upon the sophistication of the interested individual, as well as the resources (financial) that are available for that purpose.

The Purpose of a Demographic Study

It would seem that complete information about the patient population would be of extreme interest to a superintendent of an institution. As a matter of simple fact, the superintendent wants information to help him in his role of decision maker. If the data are not properly coded and structured according to his current information needs, the busy administrator often has no use for such reports.

Currently basic demographic information regarding the institutionalized retarded is relatively well known. Numerous studies have documented the male/female ratio, age , and level of retardation among an institutional population, etc., as well as the association between these characteristics. The disconcerting frequency of lower social class and minority group members among the severely retarded comes as no shock to the sophisticated (Sabagh, et al, 1959; Dingman, et al, 1967). The surveys of genetic factors continue

to reveal only a miniscule number of retardates with identified genetic problems related to their retardation (Windle, 1962).

The incidence of broken homes and deliquency follows the expectations from the lower social class and minority group experiences. The behavior disorder and the sexual problems among patients characterize the lower social class mildly retarded. The severe medical problems with somatic diagnosis, as always, reflect the severely retarded from middle class parents. The age of placement usually reflects the degree of retardation---the severely retarded being admitted young and the mildly retarded being admitted during puberty.

Most of these facts have been known for a half century or more. They were gathered as part of early federally sponsored "epidemiological" surveys of the mentally retarded. There has been great concern about the incidence and prevalence of retardation and its prevention. There has also been concern that the number of retarded were increasing proportionally faster than the general population. These "epidemiological" surveys were supposed to provide data relevant to appropriate action for alleviating some of these problems. However, the results from some of these early surveys were often used as excuses for institutionlizing the retarded as well as sterilizing them.

In recent years the goal of the survey of institutional populations has been better social planning for the needs of the retarded. Specifically, in order to decide the number and type of future beds needed, more recent studies of institutions included changes between each year-end populations of institutions in order to more accurately evaluate trends in residential populations. The results of these efforts have demonstrated the efficacy and predictability of such projections (Dingman, et al, 1964, 1965, 1969) and will be commented upon later.

The institutional staff was usually unaware of the many studies concerning release from public institutions. The monograph by Windle (1962) documented the release studies and accentuated the urgency to compare population figures over the 5 decades of reported studies. The purpose of these comparisons, and any others that could be made, was to evaluate trends or changes in release, retention, mortality and admission to institutions for the mentally retarded. In studying these trends, it is important to take advantage of all the data that are available on patients and to attempt to develop hypotheses which lend themselves to analysis of the changes.

Many states and some research institutions are now documenting their population studies through reports and journal articles. Most of the surveys, however, still take the form of an annual report to a state or federal agency. These reports are not widely circulated nor do they interpret changes in terms of relevant population changes in the community.

At the instigation of the federal government there are a number of groups studying "cohorts" or groups of patients that had been admitted during a specific period and followed for a standard length of time. The studies of population movement at Pacific State Hospital (Kramer, et al, 1957 ; Dingman, 1958; Brown, et al, 1959; Tarjan et al, 1958; Dingman, 1959; Sabagh, et al, 1959; Tarjan, et al, 1959; Windle, 1959; Windle, et al, 1959; Dingman et al, 1960; Windle, et al, 1960; Dingman, et al,1961; Tarjan, et al, 1969) were of this "cohort" type and demonstrated the high mortality rate for the very young, severely retarded patients, and the early release rate for the adolescent, mildly retarded individual. These studies illustrated the need for special programs for those patients who did not benefit by release through the existing programs. The state of California did develop foster care programs, as well as other programs for placing

younger patients in the community. A follow-up study, conducted by the cohort method a decade after the first Pacific State Hospital study, revealed a decelerating mortality rate and an acceleration in the number of severely retarded patients who were placed in the institution early in life. (Tarjan, et al, 1969).

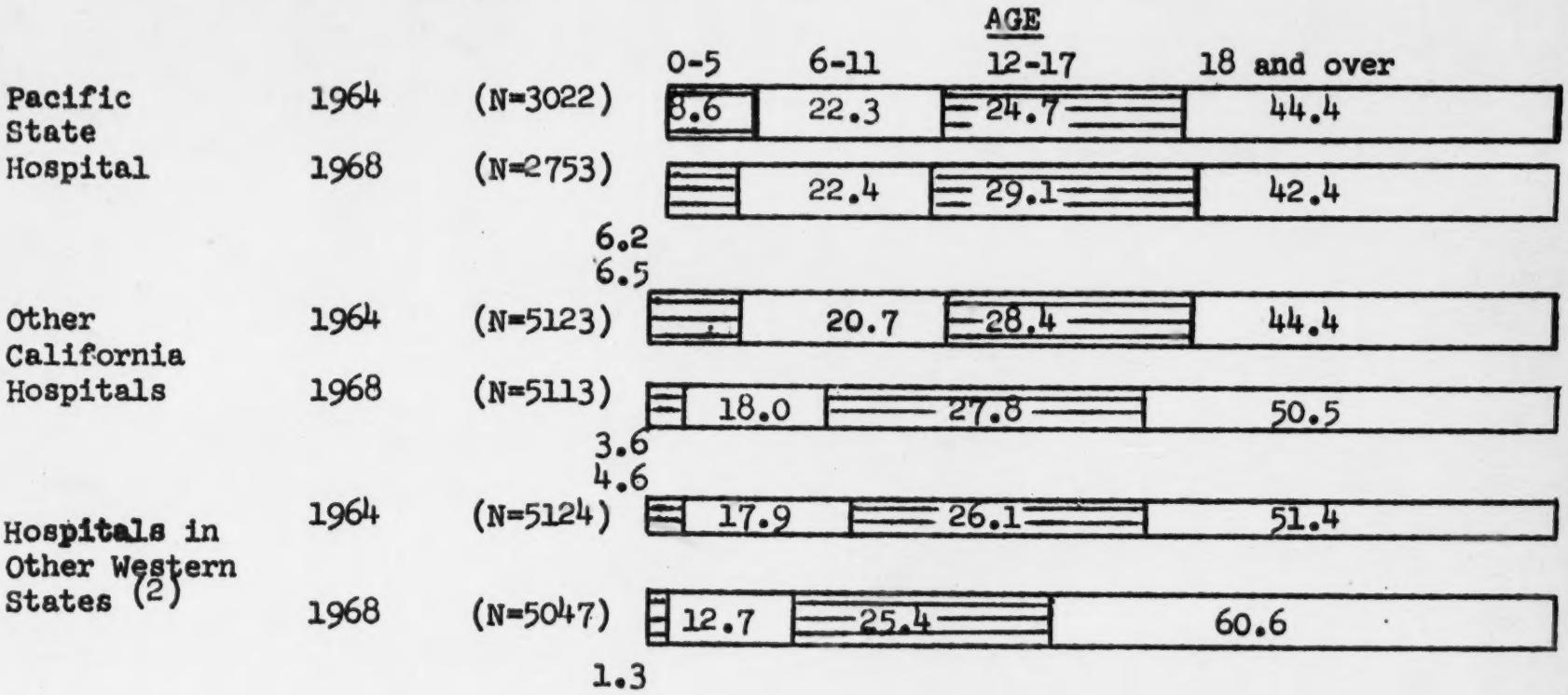
These changes are influenced by many factors. Increased medical manpower and new drugs have helped to reduce the mortality rate. Pressure of parent groups, particularly that directed toward the Legislature, has produced improved facilities for the young, severely handicapped patient. While the proportions in the later cohorts have changed, the absolute numbers of mildly retarded patients have remained nearly constant.

In addition to the cohort studies, the research group at Pacific State Hospital worked with the Westen Interstate Commission on Higher Education to carry out surveys of the institutions for the mentally retarded in the 11 western states. Annual surveys were done for several years. The published reports reveal little that is new; (O'Connor, et al, 1966; O'Connor, et al, 1967; Payne, 1968; Payne, et al, 1969; Abelson, et al, in press; Tarjan, et al, 1960; O'Connor, et al, 1964; O'Connor, et al, in press), however, the documentation on such a widespread basis at a single point in time emphasized the need for more sophisticated studies.

Figure 1

CHANGES IN RESIDENT PATIENT POPULATIONS (1) FOR AGE AND I.Q.
BETWEEN 1964 AND 1968

Note: Numbers represent the precentages of the total resident patient population for each hospital in each given year.



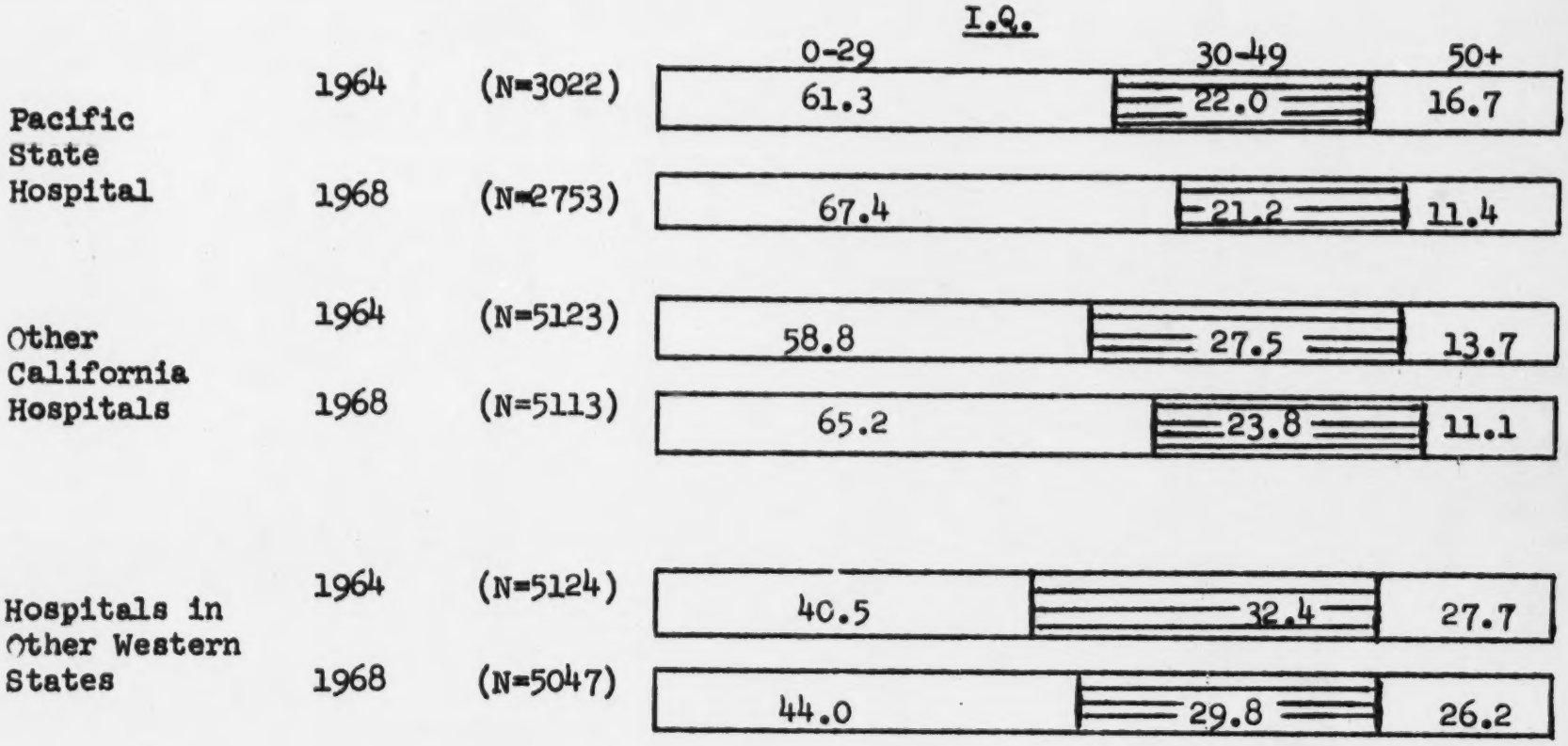
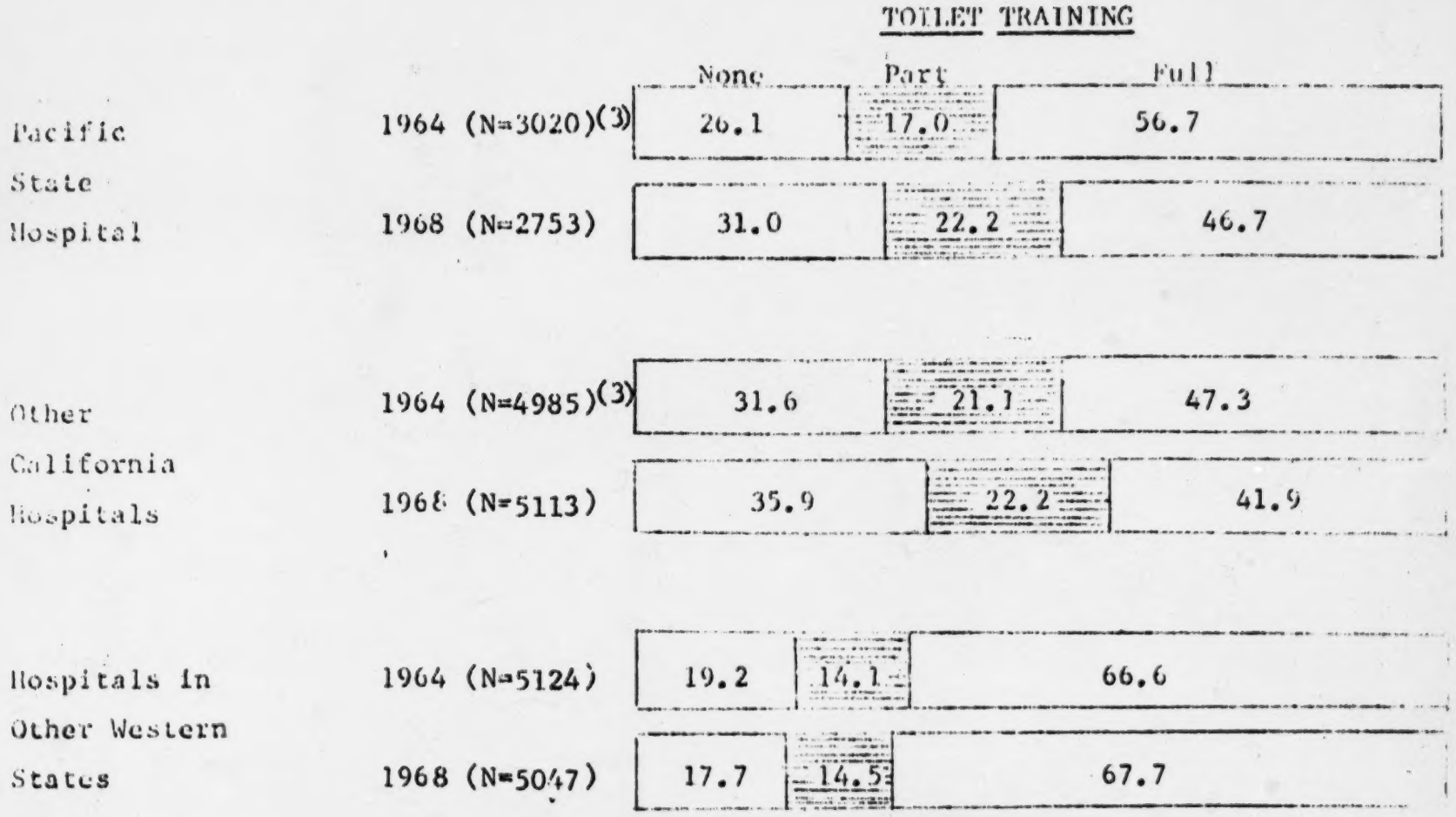


Figure 2


TOILET TRAINING
None
Part
Full
Pacific State Hospital
1964 (N=3020)(3)
26.1
17.0
56.7
1968 (N=2753)
31.0
22.2
46.7
Other California Hospitals
1964 (N=4985)(3)
31.6
21.1
47.3
1968 (N=5113)
35.9
22.2
41.9
Hospitals in Other Western States
1964 (N=5124)
19.2
14.1
66.6
1968 (N=5047)
17.7
14.5
67.7

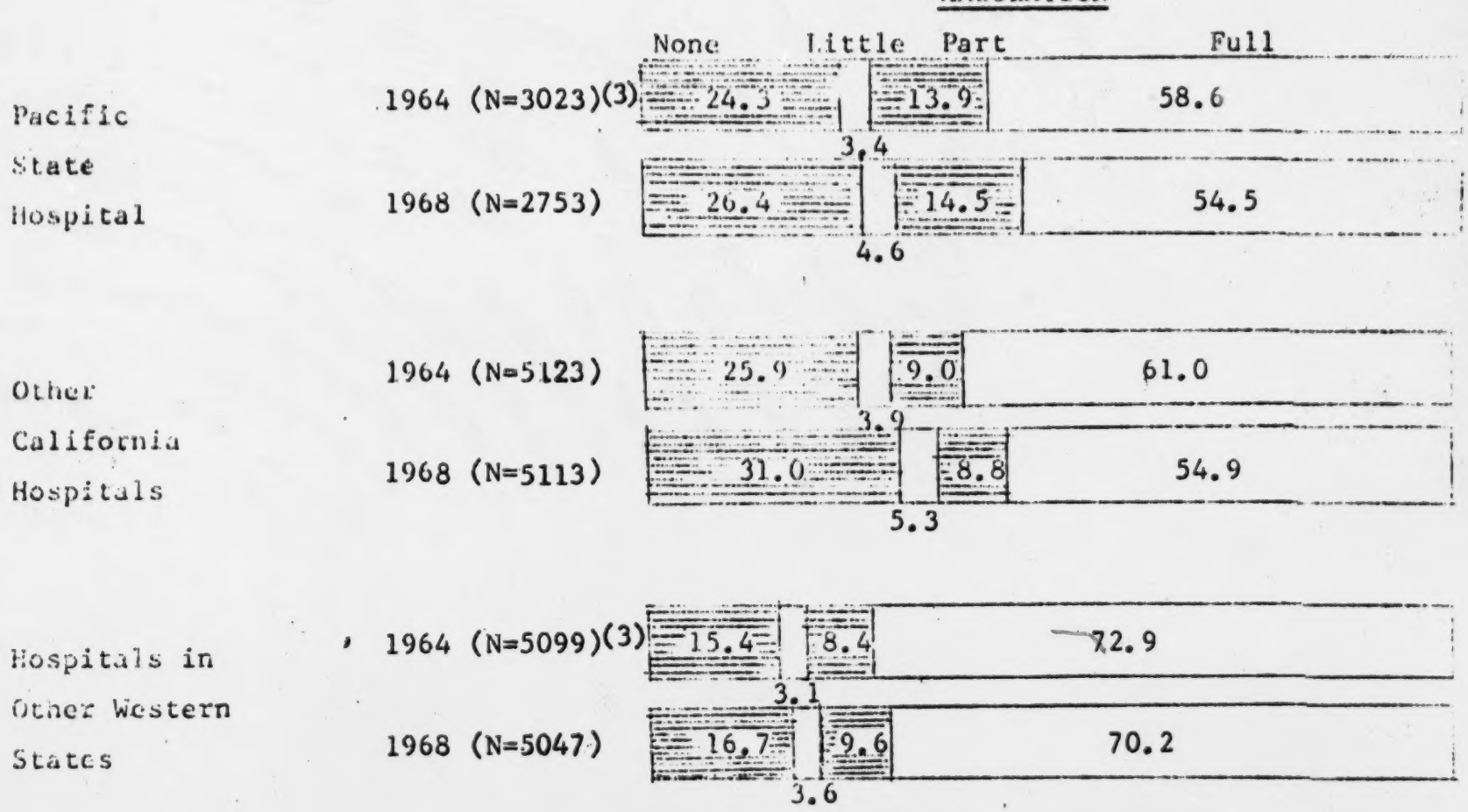

AMBULATION
None
Little
Part
Full
Pacific State Hospital
1964 (N=3023)(3)
24.3
3.4
13.9
58.6
1968 (N=2753)
26.4
4.6
14.5
54.5
Other California Hospitals
1964 (N=5123)
25.9
3.9
9.0
61.0
1968 (N=5113)
31.0
5.3
8.8
54.9
Hospitals in Other Western States
1964 (N=5099)(3)
15.4
3.1
8.4
72.9
1968 (N=5047)
16.7
3.6
9.6
70.2

Figure 3

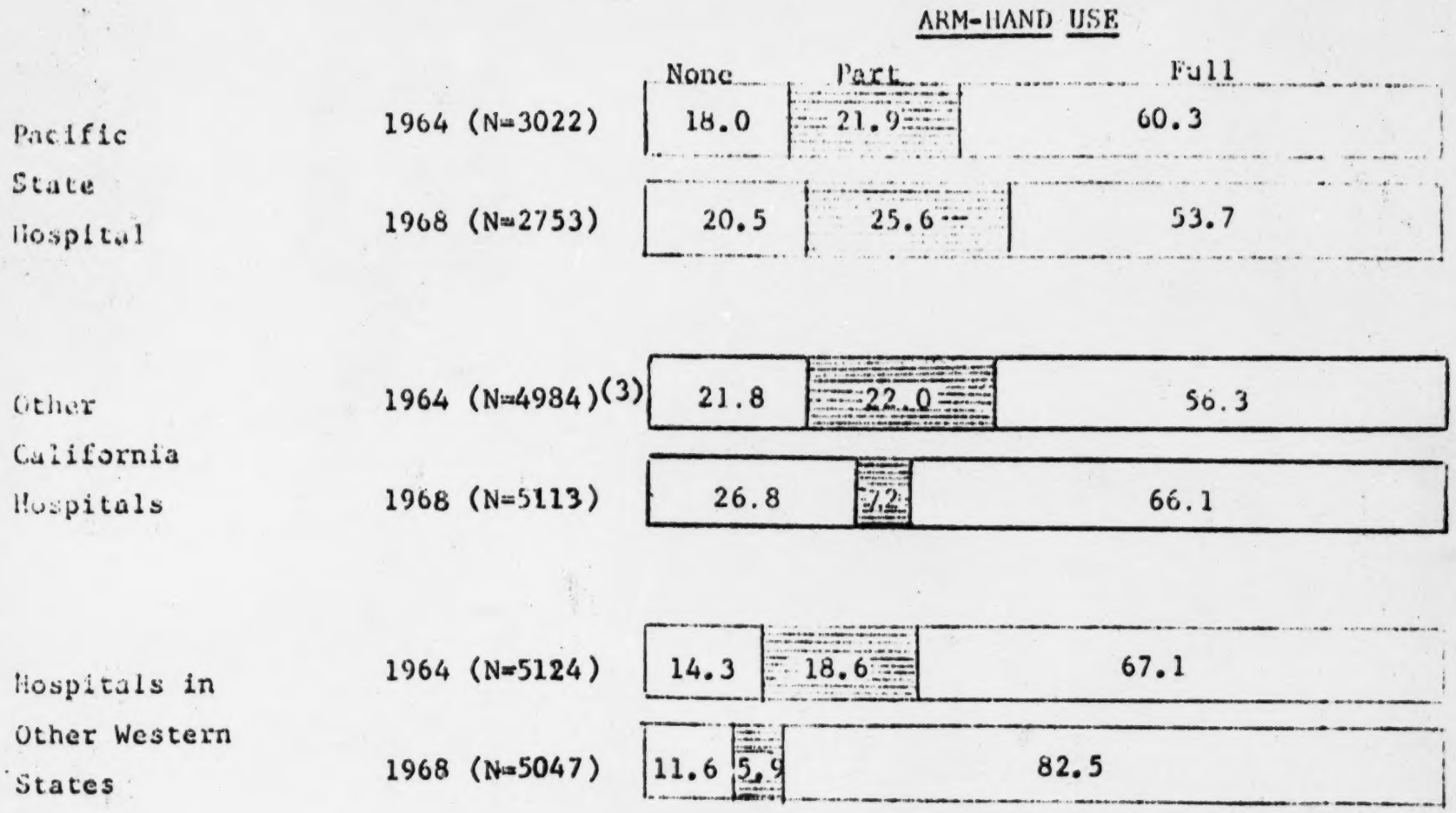
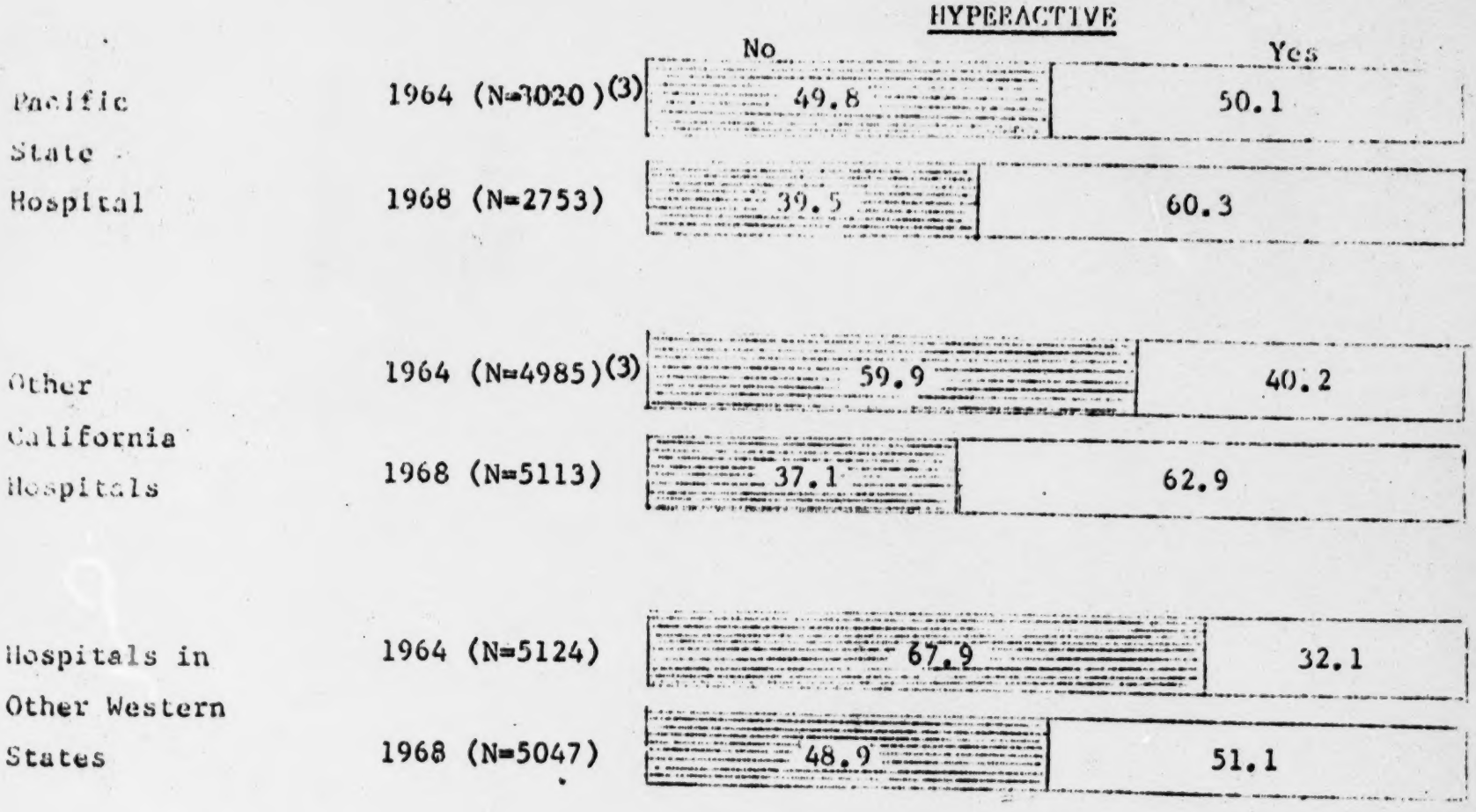

ARM-HAND USE
None
Part
Full
Pacific State Hospital
1964 (N=3022)
18.0
21.9
60.3
1968 (N=2753)
20.5
25.6
53.7
Other California Hospitals
1964 (N=4984)(3)
21.8
22.0
56.3
1968 (N=5113)
26.8
7.2
66.1
Hospitals in Other Western States
1964 (N=5124)
14.3
18.6
67.1
1968 (N=5047)
11.6
5.9
82.5
AGGRESSIVE
No
Yes
Pacific State Hospital
1964 (N=3382)(3)
56.2
43.7
1968 (N=2753)
46.9
53.0
Other California Hospitals
1964 (N=4985)(3)
71.8
28.1
1968 (N=5113)
54.9
45.1
Hospitals in Other Western States
1964 (N=5122)(3)
70.2
29.7
1968 (N=5047)
39.4
60.7

Figure 4



(1) Numbers represent percentages of the total patient population for each hospital in each given year.

(2) Other Western States include Arizona, Colorado, Montana, New Mexico, and Wyoming.

(3) Total N varies slightly because of unknown status.

Figures 1-4 illustrate changes in the composition of resident populations over a four-year period for Pacific State Hospital, other California institutions for the mentally retarded, and institutions in other western states. It is immediately apparent that there is a slight trend toward the accumulation of proportionately older patients from 1964 to 1968, particularly with reference to age categories 0-5 or over 12. It can also be seen that the type of patients appear to be more severely retarded and non-ambulatory in 1968 than in 1964. The state of California shows more consistent trends across all handicaps than can be seen for the hospitals in other western states.. The data on agressive and hyperactive behavior, however, show clearly that these problem areas have substantially increased in all the 1968 resident mental retardates who were surveyed. Nevertheless, the ratings on patient behavior are not as reliable as those for patient handicaps (Abelson, et al, in press; O'Connor, et al, 1964) so that the more definitive findings in connection with behavior could be an artifact of the ratings.

Table I

Comparison of Resident Retardates by Specified Characteristics Between 1964 and 1968

Pacific State Hospital

I.Q		Age in Years			
		0-5	6-11	12-17	18+
0-29	1964	5.3	16.5	14.8	24.5
	1968	3.9	15.6	20.1	27.8
30-49	1964	1.9	4.1	6.3	9.8
	1968	1.4	5.5	5.8	8.5
50+	1964	.8	1.7	3.8	10.3
	1968	.9	1.2	3.2	6.1

N(1964) = 3022 N (1968) = 2753

Other California Hospitals

Age in Years			
0-5	6-11	12-17	18+
4.4	14.2	17.0	23.0
2.1	13.2	19.0	30.8
1.3	4.9	8.6	12.9
.7	4.0	6.6	12.6
.6	1.6	2.9	8.7
.4	1.0	2.3	7.4

N (1964) = 4977 N (1967) = 4920

Hospitals from Other Western States

Age in Years			
0-5	6-11	12-17	18+
2.9	8.8	11.2	17.6
.8	7.6	12.0	23.6
1.1	6.3	8.4	16.6
.3	3.3	8.0	18.2
.6	2.8	6.5	17.2
.2	1.8	5.4	18.8

N(1964) = 5101 N(1967) = 4863

Pacific State Hospital

Ambulation		Age in Years			
		0-5	6-11	12-17	18+
None	1964	3.9	7.1	5.2	7.9
	1968	3.9	7.3	7.6	7.6
Little	1964	.5	1.1	.5	1.2
	1968	.4	1.9	.8	1.5
Part	1964	.7	3.2	3.0	6.9
	1968	.5	2.6	4.0	7.4
Full	1964	3.0	11.6	16.0	28.1
	1968	1.5	10.6	16.5	25.9

N(1964) = 3015 N(1968) = 2753

Other California Hospitals

Age in Years			
0-5	6-11	12-17	18+
4.0	8.8	7.1	6.0
2.6	9.0	9.4	10.0
.5	1.4	1.0	1.0
.2	1.1	1.6	2.4
.2	1.5	2.9	4.4
.1	.8	2.1	5.8
1.5	9.0	17.3	33.2
.3	7.2	14.9	32.5

N(1964) = 5123 N(1967) = 5113

Hospitals from Other Western States

Age in Years			
0-5	6-11	12-17	18+
2.7	4.0	4.0	4.7
1.1	4.5	4.4	6.7
.3	.9	.7	1.2
.1	.7	1.0	1.8
.0	1.2	2.3	4.9
.1	.9	2.5	6.1
1.4	11.6	19.0	40.9
.3	6.8	17.3	45.8

N (1964) = 5123 N(1967) = 5047

Table II

Comparison of Resident Retardates by Specified Characteristics

Between 1964 and 1968

Pacific State Hospital

Arm-Hand Use		Age in Years 0-5	6-11	12-17	18+
None	1964	3.4	5.9	3.9	4.4
	1968	3.5	6.2	6.0	4.8
Part	1964	2.8	5.9	4.4	8.7
	1968	2.5	6.6	6.6	9.9
Full	1964	2.0	11.2	16.4	31.0
	1968	.2	9.5	16.4	27.6

N(1964) = 3014 N(1968) = 2753

Other California Hospitals

Age in Years 0-5	6-11	12-17	18+
2.5	7.9	6.0	3.7
4.1	7.6	8.3	9.2
1.4	6.0	6.7	7.9
.1	1.3	1.7	4.0
.7	6.7	15.8	33.0
.5	9.2	18.0	37.6

N(1964) = 4984 N(1967) = 5113

Hospitals from Other Western States

Age in Years 0-5	6-11	12-17	18+
2.5	4.3	3.9	3.6
.9	3.8	3.5	4.4
1.2	4.7	5.2	7.5
.1	.7	1.5	3.6
.9	8.9	16.8	40.6
.7	8.4	20.2	52.3

N(1964) = 5124 N(1967) = 5047

Pacific State Hospital

Toilet Training		Age in Years 0-5	6-11	12-17	18+
None	1964	4.8	9.2	5.4	6.3
	1968	4.6	10.1	9.6	6.8
Part	1964	2.4	5.8	4.1	4.9
	1968	1.6	6.9	6.3	7.4
Full	1964	.8	8.1	15.3	32.8
	1968	.1	5.4	13.1	28.2

N(1964) = 3012 N(1968) = 2753

Other California Hospitals

Age in Years 0-5	6-11	12-17	18+
5.1	12.0	8.8	5.8
2.7	11.5	11.7	10.2
.8	4.9	7.7	7.5
.2	4.1	7.3	10.5
.4	3.8	11.8	31.3
.2	2.5	9.0	30.0

N(1964) = 4985 N(1967) = 5113

Hospitals from Other Western States

Age in Years 0-5	6-11	12-17	18+
3.2	5.9	5.3	4.5
1.2	5.0	5.2	6.8
.8	4.4	4.2	4.9
.2	3.6	4.5	6.3
.5	7.5	16.5	42.2
.3	4.5	15.6	46.9

N(1964) = 5124 N(1967) = 5047

Tables 1 and 2 provide a further breakdown of the changes in the composition of resident populations over the four-year period by the three sets of institutions. In this instance, the percentages of the specified total patient population were cross-tabulated so that trends of IQ, ambulation, toilet training, and arm-hand use could be examined by age. As can be seen, the proportion of mental retardates with low IQ's shows a decrease in the younger age group and an increase among the older patients.

In general, the same is true for difficulties in ambulation, toilet training, and arm-hand use. Thus the changes over a four-year period reveal an increase in the number of institutionalized, older mental retardates whose problems obstruct their release. In contrast, younger patients, although admitted in greater numbers, are being released at a higher rate (Tarjan, et al, 1969). In other words, the slight but evident decline among the younger, more severely retarded patients is explained partly by the emergence of suitable release programs for these patients, i. e., foster care programs, etc., and partly by the lengthening age of some patients to the point where release becomes difficult.

In addition to foster care programs, nursing homes are emerging as possible release outlets for the mentally retarded in connection with Medi-Cal funds. Although both of these community placement alternatives are tailored for the young, more severely handicapped individual, not all of these children will be placed. There is some evidence that acting-out behavior problems, as well as a prominent lack of ambulatory toilet skills, make it very difficult to place the child, regardless of

nursing and foster care homes. Institutionalized children who are likely to acquire acceptable behavior and self-help skills generally do so within a year after admission (Eyman, et al, submitted AJMD). Children who do not show improvement are probably those who will continue to collect in institutions and comprise the older group of resident patients.

Many of the changes noted reflect program changes, rather than something that is happening in the population itself. The state of California has been enlarging its available school programs for the mentally retarded. It has been postulated that the program of community classes for the trainable mentally retarded children in foster care homes and when they're eligible, they are returned to public school classes for the trainable mentally retarded by the foster parents rather than an original placement by the parents themselves.

It is probably also appropriate to comment additionally on the child who is <u>not likely</u> to find his way into one of the classes for the trainable mentally retarded. To begin with, among other problems, many retarded children are not physiologically capable of being toilet trained at a younger age. There are, however, some older individuals who theoretically have control over the musculature yet somehow remain untrained. It is this group of retardates who draw attention because it is this group that we are going to be seeing more and more of in institutions. These are the individuals who are going to be institutionalized until someone develops a program for them.

Two additional types of surveys need to be mentioned. One is based on cross-sectional data for a given year, similar to that presented in this paper (Tarjan, et al, 1960). Topographic charts were drawn, which depict percentages of various handicaps in new admissions and in resident patients,

relative to age and IQ. In the set developed for Pacific State Hospital, the difference between the admission group and the resident patients revealed a saturation of the higher IQ, older, handicapped resident patients. Identical results were found on completion of a similar analysis of resident patients in institutions from the 11 western states cooperating on the WICHE data collection project (O'Connor, et al, in press).

The second and perhaps most important type of survey involves utilization of many variables in development of typologies of resident mentally retarded patients. The release, retention, and death of specified groups of mental retardates, based on these typologyies, can reveal the role played by variables related to patient handicaps in the dynamics of an institution.

For example, Dingman (1959) demonstrated that it is possible to statistically validate the notion that there are two major types of mental retardates, a notion that has been held for many years by workers in the field. The advantage of such validation goes beyond simple confirmation. Utilizing probability techniques, it was possible to assign patients on a routine basis to their most likely classification. It would have been difficult, if not impossible, to formulate the rules by which the staff of the institution would assign patients to one category or another.

Subsequently, Miller, et al (1962) utilized the latent class model to classify patients into the two groups. One of the groups contained almost all of the patients who would be likely to die within the first year after admission; thus, membership in this group was predictive of a greater chance of death. Depth predictions of those newly-admitted patients were routed to the hospital staff for a seven-month period. Four patients, who were admitted during this period, died---all from high-risk group. Since it was expected that 13 patients would die, it could be considered that the experiment was a success. The medical staff had been alert-

ed to the patients who might die and were able to take preventive action. In fact, certain staff members verbally reported that they regarded the prediction of mortality as a challenge to their medical skills. The physicians felt that the study was at least a partial success because it had alerted them to the types of patients who require special attention, who were then given such attention. The overall well-being of the patients had been improved. This hypothesis was further supported by the fact that after the predictions were no longer made, the mortality rates returned to their former levels. The same variables and the same formulas have been used with reasonable success, for the mentally ill in Austin State Hospital, Texas (Witzke, et al, 1969).

Discussion

The present nature of residential populations is undergoing some changes,, which are partly due to the development of new programs outside the institutions, and partly due to construction of new facilities. Various methods of studying the institutionalppopulation give rather consistent results. No model of the institutional population represents our total understanding of the population. For example, it is not unusual for school teachers and principals to search institution records and visit wards in an attempt to locate patients who can be taken from one program and placed into their programs. Conversely, hospital staff, having more capable patients working in their programs, are likely to build defenses so that the patients will remain. These selector dynamics usually do not find their way into population models. The successful models are, at best, an ad-hoc set of procedures from which to draw conclusions on data that has already been collected.

More specifically, as shown by the results presented in Tables 1 and 2, the changes in the composition of Pacific State Hospital were

not as consistent or evident as those of other hospitals. In the past, Pacific State Hospital had greater access to extramural program funding than some of the other institutions. Hence, the most dramatic changes in the population at Pacific State Hospital occurred between 1952 and 1963, as reported by Tarjan, et al (1966). Regarding the large increases noted for behavior problems, it would appear that institutions have failed to develop programs for coping with them.

As for the use of a typology, it may be possible to develop prediction and control systems on the basis of our knowledge of the typology. A formal system of predictions and testable hypotheses are necessary for a clear indication that we understand the nature of the residential populations and that we are prepared to control the social forces that produce unwanted changes. To continue to collect data and develop new programs as they appear necessary is to simply respond to ever-increasing numbers of fire alarms. The social process of serving populations should require a more thoughtful, foresighted, and understanding approach.

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III

Multidimensional Problems of Administration in a Residential Setting

Mr. Harvey Stevens

Over 3000 years ago the Pharoahs of ancient Egypt constructed the pyramids. One thousand years ago, the Romans built the aqueducts. Several thousand years ago, the Aztecs erected large temples. Today, no one in his right mind would undertake projects of this magnitude without an array of construction equipment, along with the necessary power resources such as oil, gasoline, electricity, steel, dynamite, etc. Yet, these resources were all unknown at the time these projects were constructed. In spite of this, they were built.

How can these feats be accounted for? At that time, there were few known mechanical aides--the wheel, the lever, the pulley, water power and rudimentary gears may have been used in one form or another. These accomplishments must have been accomplished through the highly coordinated efforts of people. One must assume that there existed a vastly complex, highly integrated organization of people. This organization was brought to bear upon solving this incredibly ambitious construction problem.

All of these great accomplishments of antiquity can only be explained in terms of the use of a human organization. The Great Wall of China, the irrigation canals of the Nile Valley, the Acropolis, the great cathedrals of Europe--all were products of highly coordinated human efforts.

As early as three centuries ago, it was possible for a single man to master all of the formal knowledge recorded by Western civilization. He could be a man who knew everything. He was even capable of, in his lifetime, developing some degree of proficiency in every skill known to man at that time.

Today the mere act of attempting to read everything written would require several lifetimes of one man. It is no longer possible for any one individual to be fully informed about every field of formal knowledge--let alone be a master of every human skill. He can, however, learn to understand problems or events to a degree never before open to him. He may achieve a degree of self satisfaction by probing in depth some one class of problem. He can follow his interest to learn and understand those things that concern him. He is bound to a human system--for without it he would be reduced to the basic animal instinct of self preservation.

The human organization is, in reality, the emancipator of mankind. It surpasses the limitation of the individual. In so doing, it makes the individual totally dependent upon the very system which permits him to use and develop his human qualities.

The dilemma of man today is that he is dependent for everything he has upon the human system. Man is able to realize his fullest potential of his individuality because he is part of the system. Yet, he becomes an individual only through his dependence upon a human system.

Of importance to the individual is the great variety of suborganizations which constitute his immediate environment in which he lives. His family, his neighborhood, his city, his club, his lodge, his church, his friends--all are important groups within his life. The average person seldom thinks of these subgroups as systems, but that is what they are. Each system is composed of people who make specialized contributions to the group--centers of controls which specify and limit activities in predetermined ways. Broadly speaking, each group is a goal-seeking unit. Each is a human system.

The residential institution is different from other human systems only in the degree to which it is more precisely constructed, more specific in its goals, possessed of a greater amount of human resources and more specific in the application of its human resources to the resolution of its problems.

An organization of people who share common goals, who relate to one another in some particular way, and whose energies are coordinated toward the achievement of a common goal is, in reality, a mechanistic system. Only when the system and its people are permitted to grow and develop to meet changing needs, utilize new technologies and new information does it really constitute a human system.

The traditional residential institution has been and continues to be a mechanistic system. The people in such a system are easy to replace. Anyone with a little energy can construct and manager such an organization. Some progress can be achieved by providing a little more energy to the system than anyone else does.

The human system is different. The human system is capable of growth--purposeful growth. It is capable of adapting to changing needs. It is capable of meaningfully integrating into its system new knowledge and utilizing new techniques without undue disruption. Coordination serves to develop its potential rather than control performance.

The organization is not a tangible thing that can be touched or manipulated; it is an idea--a concept--that ultimately depends upon people to achieve its objectives and its function.

The effective organization is basically an outcome of the values of its individual participants. There is, however, more to it than this.

Organizations develop habits, traditions, weaknesses and strengths which can come to represent more than its current staff or current leadership. The organization can preserve values and pass them on to new members. The fact that every human system and every institutional organization is a goal-seeking, self-preserving entity, and that each can preserve and pass on its values, means that each is a vital and powerful entity. It can create and it can destroy.

The values that are established by the organization are of the greatest importance. Without them, it cannot coordinate the activities of its members and it may hazard its own destruction. The human organization must have access to an awareness of its values and the inherent capacity to alter them, to modify them, if it is to grow and develop.

The current concern of institutional organizations with human relations is a symptom of the organization's need to maintain itself internally in a healthy state. Moreover the institution which fails to take into account the influence of political and social forces may be an unrealistic one. The institution which makes the erroneous assumption that it has the right to be independent of its social and political setting can anticipate difficult times for itself.

The healthiest state for any organization appears to be a developmental course which leads to interdependence. Interdependence is unquestionably at the very core of so-called dependency relationships. Employees depend upon the employer for the tools, the techniques, the materials and the salaries. The employer, in turn, must depend upon his employees intellectual to use the resources in a productive manner in order to achieve the institutional objectives in an efficient and economic manner.

In the human organization everyone is interdependent with nearly everyone else. Specialization forces each individual to depend upon the others and to be dependent upon others. The human system, if it is to function effectively, must foster awareness of and give increased attention to interdependence. Only when it does can it achieve full command of all of its resources, through efficient use of its human resources and adaptability to the needs of the members it serves and is responsive to the demands of society.

Organization theory during the first half of this century can be characterized as being mechanistic in its approach to human organization. This model has produced many deficiencies. This type of organization operates fairly efficiently. Its people can be readily and easily replaced. It can be productive for a long period of time. It is totally dependent upon its input--quality of leadership and technical people. It is extremely limited in modifying and responding to changing technology. Its output is limited and it is inflexible. It often increases efficiency by decreasing the quality of output. Coordination of effort in this type of organization is achieved primarily by pushing and prodding people through established channels.

The mechanistic type of organization approaches obsolescence very rapidly. They do not grow or respond to changing philosophies, new knowledge or procedures. They often lose sight of their basic organizational objectives and goals.

The organization which is fully integrated with its staff and the community and is responsive to its social and political environment and is capable of critical self evaluation becomes a dynamic and productive one. In achieving this, it must balance coordination with autonomy--order with capability for change, economy with growth. Such an organization is a sophisticated one, a complex one and constantly directs its people to achieve an efficiently operated organization. The administrator of such an organization is responsive to change and a master of transition.

If there is a recognizable change in residential administration today, it is toward a greater interdependence of component parts, toward greater clarity of organizational objectives and departmental goals, toward greater integration and assimilation of newer concepts and ideas. Unfortunately, at this point in time, this type of organization construct is not fully understood, much less mastered in its application.

Yet, it is clearly evident that to change the function and the ability of residential programs to achieve acceptable status, it must change its basic organization structure from a mechanistic one to a humanistic system. Autocratic leadership must be replaced. It must, of necessity, involve the decision makers at all levels of operation. To do less is to remain static and await the day of eventual public outcry for change.

Authority and power are the basic elements of the human organization. The way that authority and power are utilized has done more to permit the organization to achieve its goals than any other factor, except competent specialization. Tragically, it has also been the organization's greatest source of mismanagement of personnel and barrier to attainment of its established goals.

The surrender of individual power is a high price to pay--yet by so doing it has permitted the modern organization to advance to heights heretofore unachieved in administration.

The real function of power in today's organization is to place the highest priority on the achievement of the organizational goals as opposed to the attainment of the individual goals. This emphasis or focus permits the leadership people in an organization to pursue the attainment of complex goals and objectives by utilizing groups of people--working in concert toward common goals.

The amount of power that must be applied in order to attain the organizational objectives is proportionate to the degree to which the personal goals of the individual match those of the organization. The individual whose goals are incompatible with the organization's goals must, if he is to contribute, work toward them or eventually leave.

The most elementary rule of organizational power is: the fewer the individual needs and goals which the organization can satisfy, the greater the power which must be applied to gain his cooperation in achieving these goals. Conversely, the greater the proportion of personal goals satisfied by the organization, the less power which must be applied to attain the individual's contribution to these goals.

One obvious indicator of the amount of power being applied to gain compliance with the organizational objectives is the amount of friction or emotion generated. Emotional reaction represents inefficient use of power. An organization which generates emotional conflict is an organization that can be run with minimal integration of its members but at a significant and tragic loss of each individual's potential.

We live in an age when we must make the fullest use of available manpower, particularly highly specialized manpower. How we use this available manpower today foretells how efficient an organization one will have in the future.

Today's administrator must not only know the technical system he manages and be able to deal effectively with the people in it, he must also learn how to integrate the technical systems, the organizational systems and the individual systems into a meaningful, productive relationship. This is no small task!

He must foster interdependence among individuals, groups and technical activities. Frequently, the individual is unable to identify the bulk of his personal goals with the organizational goals because he is never given the opportunity to do so!

If the employee's work is routine and repetitive, he quickly overlearns the skills involved in it and soon learns to set a leisurely pace for himself. He knows little or nothing about the problems in a nearby department and much less about the institution's objectives. When problems arise in his own area, he may not know why but only that the supervisor wants them corrected or eliminated. He interprets this increase in pressure not in terms of the attainment of the institution's objectives but, rather, as a potential threat to his own security. He is convinced that higher productivity and increased efficiency will not be accompanied by increased pay. He is convinced that if he gets involved in an argument with his co-worker or his supervisor, he can expect that judgment will be made of the situation without due regard for his personal concerns. He is isolated and some distance from the organizational goals--and his own goals--so he retreats into apathy, noncommitment or ultimately resigns.

If his job only satisfies his minimal needs, he will only contribute minimally to the job and ultimately only marginally to the institutional goals.

All too often, the average employee does not know what the current priorities are, how they have changed or, more important, how they were arrived at in the first place. Frequently he is kept in the dark even when he is to contribute a vital piece of information to a very important overall department or institutional effort.

The ugly truth is that an administration must work hard if it is to involve any significant portion of its members in its objectives. The average person will not casually commit himself. He must be sold on the idea; he must be catered to. Loyalty and commitment involve and develop out of intense personal interaction. Most employee apathy and lack of commitment is a result of the administrator's failure to deal more effectively with the employee.

The administrator who can help his people get past a crisis successfully, who himself is a producer, who is consistently reliable and, above all, provides the method for solving a problem or responding to a need develops a source of personal power which is immeasurably helpful to all concerned. This type of power is derived from the administrator's relations with his staff. There is seldom anyone else on whom the employee can depend when they encounter a problem too tough to solve alone, or when they cannot make headway with another employee or department. Thus, the administrator's ability to help his staff members resolve a problem, or backing them up is a very real source of power.

The administrator who knows how to help people do their work and who works hard to make it possible for them to accomplish what they are charged to do--or set out to do--is the one who is making effective use of his power.

The administrator is expected to be a general expert. He may have been the best teacher or clinician in his field before he was promoted, but if he cannot expand his abilities to respond to human needs and problems of his staff, he may well fail in his major responsibility both to the staff members and to the organization.

With an institution, the technical problems are frequently the simplest aspects of the total problem. The lack of competence to deal with the entire organizational system probably ranks as the greatest cause for administrative failure.

One of the greatest sources of power available to the administrator is reward. The simplest act of recognition of an individual is a powerful one.

The effective administrator takes care to know his staff's names, by recognizing them in a pleasant way when he encounters them, by indicating what he likes and what he dislikes about the way a job is done. This list can be expanded and by their use the administrator can use them to increase his influence on employee's performance.

Money, incidentally, seems to have only a minimal effect as a reward.

To ensure the effects of a reward upon performance, it must be given as close to the performance as possible, and must be withheld from poor performance (a la behavior modification). Few administrators in public institutions have the authority to dole out monetary rewards. Thus, it is essential that other types of rewards be used.

The alert administrator will also assume the responsibility to learn what type of reward is most effective with each of his staff members. Rewards have differing values to different people. The ability to make effective use of rewards is dependent upon another skill--that of being able to identify what performance is effective and what is ineffective.

Like (p. 42) has listed the following examples as rewards which can have a positive impact upon an employee's performance:

--spending time in personal contact with the employee
--providing direct assistance when the employee needs it
--knowing the employee's name, wife's or husband's name, personal concerns, special interests, etc.
--assigning an employee, even temporarily, to a job he values or aspires to
--permitting the employee time off to attend to personal matters
--permitting the employee an opportunity to represent you or your department at a meeting
--delegating full responsibility to the employee for certain jobs
--nominating the employee for special awards or recognition
--covering or correcting obvious mistakes on the employee's part
--recommending the employee for advancement

This list is only a starter--each administrator needs to develop his own reward system. In the past, this type of reward has been overshadowed by money. Such rewards should become part of each administrator's daily operating procedures.

One of the strongest source of administrative power is to have clearly defined objectives for his organization or unit. These need to be implemented with well-stated goals on how these objectives are to be reached. Each and every employee should clearly understand what his job is and how it contributes to the attainment of the organizations objectives and the unit's goals.

People generally undertake a task which they feel to be important and stick to it to its completion. Providing people with goals and with the opportunity to work toward and achieve these goals is a strong motivating force within any organization.

A negative power of an administrator is the utilization of punishment. Suspending employees, reprimanding an employee in front of his peers, sending letters of reprimand, causing forfeiture of salary, not rewarding an employee when other employees were rewarded, are all common methods of punishment. Punishment is, in effect, the administrator's way to establish the tolerance limit of an administrator for unsatisfactory job performance or behavior.

Punishment is never considered by the employee as helpful so it is naive of an administrator to think it will improve job performance. Usually it results in producing a hostile or defensive employee bent on seeking revenge.

Discipline, to be effective, must be used skillfully and sparingly. Wholesale punishment of employees only serves to divide the employees and tends to tear the organization apart. Unwise and unjust punishment does the same thing.

Ordinarily, the average employee is probably sincerely committed to his organization, it's usually the way in which the organization handles him and treats him which makes him a productive or non-productive employee, and a loyal employee instead of a disgruntled employee. Punishment serves the organization only when it is used sparingly.

Maybe a successful administrator is one who possesses personal resources of power enough to carry out his job. The effective administrator contributes to the effective utilization of his staff to achieve the organization's stated objectives and goals.

What, then, is the job of an administrator? What must he do to become efficient; successful? If he is to survive, he must develop proficiency in most of the following areas (Likert, p. 197):

--relating to individuals
--relating to the organization as a whole
--controlling the technical aspects of the job
--solving problems
--setting priorities
--recognizing motivational cues in the behavior of others
--dealing with emotional situations
--handling his own emotions and being objective when necessary
--supporting other members of the organization when required
--becoming involved with other people when the situation demands
--managing conflicts
--negotiating effectively

The style of management that the administrator finally develops depends to a large degree upon the character of his organization and the value system that organization has developed.

The art of administering is founded upon the art of evaluation. There is no simple system; there are no set rules; no permanent guidelines with which to define the value priorities of either the organization or the individual. Mastering of the evaluative art in leadership cannot begin without a full comprehension of one's own human qualities, potential or emotions. Without it, leadership itself is no more than a mechanical ritual.

IV

The Current Status of Education in Residential Settings in the United States

Dr. Wesley D. White

Less than ten years ago, Dr. Arthur Fleming, then United States Secretary of Health, Education and Welfare, speaking at the annual meeting of AAMD, referred to our residential facilities for the mentally retarded as "America's national disgrace". MR 67, A First Report to the President on the Nation's Progress and Remaining Great Needs in the Campaign to Combat Mental Retardation states, "Renewed attention must be given to public facilities and programs for the five percent of the mentally retarded who require full or part-time residential care. These (referring to the residential facilities) have not kept pace with progress in community activities on behalf of the retarded. Some of the best residential programs represent triumphs of resourceful staffs over cheerless facilities, penny-pinching budgets and general indifference. Many are plainly a disgrace to the nation and to the states that operate them."

On the 16th of February, 1968, Dr. Wolf Wolfensberger, Mental Retardation Research Consultant to the President's Committee on Mental Retardation, and I attended a meeting of the State of the Nation Sub-committee of the President's Committee on Mental Retardation. Dr. Gunnar Dybwad, who was also an invited guest at this meeting, noted that three-quarters of the nation's more than 200,000 institutionalised retarded live in buildings 50 years old or more -- a number of these buildings dating back into the 19th century. He, too, emphasised that many of our state institutions for the mentally retarded are "a disgrace to the nation and dehumanise and degrade those in their care. Archaic and now discredited concepts are cast into mortar and steel, impeding progress into a hopefully better future".

At the above-mentioned meeting, Wolfensberger discussed the relevance of the concept of deviancy to mental retardation. He pointed out

that retardation is by definition a deviancy, and that many retardates are stigmatized by overt signs of their deviancy which elicit negative social reactions. However, mental retardation is only one of many types of deviancy, and society tends to react against deviancy in general. Indeed, if one compares the ways in which various types of deviancy have been handled in our society, one will find that practices in one field of deviancy were usually preceded or followed by about 10 years by similar practices in other fields. Four historically common ways in which society has dealt with deviancy are:

1. to prevent it
2. to reverse it
3. to segregate or isolate it
4. to destroy it

At first, the major goal of residential facilities was to <u>make the deviant undeviant</u>. Seguin, Howe, Wilbur and other pioneers believed that through education and training the retarded could be enabled to live more normal lives in society. The first institutions these pioneers created were small, home-like and located in the heart of the community. A careful study of the records show that these institutions were remarkably successful in achieving their stated purpose: contrary to our history texts, many residents were returned to society. For example, by 1869, eighteen years after Howe had founded the Massachusetts School, its total enrollment was still less than 90. During that period, 465 children had been admitted, and 365 had been discharged, many of them as self-supporting members of the community.

As the early idealists were replaced by others, and as non-rehabilitated residents accumulated, the objective of the residential programs

changed to one of protection, emphasizing sheltering the deviant from society. However, to shelter meant to isolate. Furthermore, asylums, standing in less repute than schools, placed more emphasis upon economy. One way to economize was to make use of institutional labor, and to crowd residents into buildings, and the groundwork for exploitation and warehousing was laid.

Soon, pity changed to fear and scorn, and new dedicated and vocal leaders began to urge the protection of society from the deviant. From 1880 to 1925, mental retardation was considered to be a major menace, a malignant growth in society, which society, in self-protection, had to eliminate. During this period, laws were passed forbidding marriage, and permitting or mandating sterilization and the permanent segregation of the feebleminded. It became the consensus of the professionals in the field to isolate and warehouse the retarded deviant as inexpensively as possible for life, to prevent his reproduction, and thereby exterminate the condition. Economy was stressed so that as many deviants as possible could be segregated. Efforts to cut costs led to institutional peonage so that not even the most promising residents were rehabilitated. This concept of the retarded deviant being a menace led to the dehumanization in our institutions.

As a result of research and new knowledge, old rationales were discarded between 1918 and 1925, but through our failure to develop a new philosophy strongly backed by dedicated and vocal leadership, the old ways have continued to the present by their momentum. For example, it was not until the end of the 1950's that cages which lined the walls of the day halls at the state institution in Grand Junction, Colorado, were removed.

The North Campus of the Wheat Ridge School near Denver has a series of buildings constructed in the early 1960's. These now have interior patios which in the original drawings were cell blocks. The buildings would have been constructed with these concrete, windowless cells had State administration not moved under new leadership at that time. In Wyoming, Dr. Heryford inherited facilities which contained many cells - facilities, some of which opened after 1960. Ridding the facility of these cells and the philosophy behind them was a monumental task to which he has devoted much time these past seven years.

In order to build for the future, it is necessary that we understand how the facilities with which we live came into being and to realize that we cannot just modify or patch up these monstrosities. What we need to do is to begin with new ideas, new concepts leading to new goals -- concepts based on today's knowledge and a respect for the human dignity of all.

Let us briefly trace the transition from the educational objectives of the early pioneers to the work of the dehumanizers, a number of whom gave much of the leadership to the American Association on Mental Deficiency, during its first forty years of existence.

Dr. Edouard O. Seguin inspired Dr. Hervey B. Wilbur of Barre, Massachusetts, and Dr. Samuel G. Howe of Boston to begin efforts in behalf of the feebleminded of their state. Their zeal and enthusiasm brought attention and legislative support. Their work was towards amelioration of the condition of the feebleminded.

The successors of these dedicated early pioneers did not continue their philosophy and beliefs. The small schools grew and became large. Their level of success declined. Philosophy changed and soon the dehuman-

izing process began.

When the American Association on Mental Deficiency was formed in Elwyn in 1876, Seguin was its first President. With the continued growth in size of the institutions, with the shifting philosophy of new leaders, Seguin's concerns were such that he disassociated himself with the new leadership and new philosophy and created a model private school which remained small and devoted to the education and rehabilitation of the retarded.

By 1885, Dr. Kerlin, who also served several terms as President of AAMD, was Chairman of a standing committee on Provision for Idiots of the Conference of Charities and Correction. In the report of that Committee, Dr. Kerlin mentions moral imbeciles and states that they should be subjects for life-long detention.

Other reports to this Conference, in the following years, stated that life care must be provided for all feebleminded as economically as possible. These reports claimed that life care is less costly than allowing the retarded to multiply. The older, more capable ones should be held for life-time work, i.e., (institutional peonage)

In 1897, Dr. Powell, in his report, recommended the permanent institutionalization of all grades of the mentally retarded and legislation to sustain and enforce methods of prevention. Besides the feebleminded, it was recommended that another group of deviants, viz., the epileptics, be isolated. Dr. Carson, reporting in 1898, stated that the census of 1890 listed 95,571 feebleminded in the United States and lamented that only 7,000 of these were in public institutions, especially designed for them. He went on:

The fact that there has been such an increase in their number,

> and that so many are unprotected and unprovided for, is sufficiently deplorable in itself; but even more so is the fact that the existence of so many feebleminded establishes a centre from which emanates an almost endless chain of evil. These 95,000 uncared for we find to be not only a burden to their relatives and friends, but also a burden and menace to the public by their reproduction of other mental weaknesses -- insanity, epilepsy, pauperism, illegitimacy, and every form of degeneracy.

In the same year, an article published in Education Magazine, written by Henry Clapp, recommends removing all feebleminded from the public schools and placing them in institutions where they may be permanently segregated and trained to work.

Written in 1904, the book, Mental Defectives, Their History, Treatment and Training, by Dr. Martin W. Barr, another past President of AAMD, is a classic. The book is "dedicated to those whom the French have so touchingly named Les Enfantes Du Bon Dieu and to a mother deeply interested in them." In the Foreword, he emphasized "the utter hopelessness of cure, and also the needless waste of energy in attempting to teach an idiot". In speaking of the moral imbecile, he points out the absolute necessity of life-long guardianship and that the "healthy status of a nation depends upon eliminating from its arteries this most pernicious element" (and placing them) "where they may live out their brief day". The brevity of the day of the retarded in the institution is well illustrated by his death statistics. Less than a third of those committed to the tender care of the Elwyn School lived to the age of twenty. Eight out of 625 made it to forty. The most common cause of death was phthisis although a smaller percent died of consumption at Elwyn than statistics quote for institutions as a whole across the country. One writer gives the number of deaths caused by phthisis as over fifty percent.

In advising parents who inquire if a child will outgrow his defect, Barr states:

> . . . To this, there is but one answer. He who is born to this sad heritage leaves hope behind. We cannot cure what is not diseased but defect and that which the cradle rocks the spade will cover.

He makes a strong plea for desexualization, devoting an entire chapter of his book to it. He cites the improvements in the behavior of boys after castration and recommends it be done as soon as the retarded condition is discovered.

In describing a case history of a moral imbecile, he concludes, "If phthisis would develop, it would be the happiest issue".

He states that:

> (There is) a dangerous element in our midst, an element unprotected and unprovided for, this is our heritage from the last century. The safety of society, therefore, demands its speedy recognition and separation in order to arrest a rapid and appalling increase, and furthermore, its permanent detention lest it permeate the whole body socialistic . . .

And Barr continues:

> It is not for the mother whose child is dead for whom we should feel the deepest sympathy, but rather for her who lives in the valley of sorrow, and who never can bury her dead out of sight nor know true peace until her boy has passed to that far country where dreams come true, where griefs are changed to joys, and hopes to realities.

Planning for the mentally retarded during the last twenty years of the 19th century and the first part of the 20th century was a monstrous warping and twisting of the idealistic programs started by Seguin, Wilbur and Howe. This is the philosophy that is cast into the masonry and steel of more than half of the archaic facilities in use today. Although the just described philosophy and planning have been thoroughly discredited, it ma-

vives in many of the institutions that we operate. Operational procedures and ways of doing things from this unholy past are millstones around the neck of this organization and many of its professionals, which, if not gotten rid of, should drown us.

As has been pointed out, early concepts about the attitudes toward mental retardation made institutional care a kind of warehousing problem: the idea was to keep this living "waste" from contaminating society, to keep them secured out of sight and out of mind.

Since the retarded were considered as sub-human, there was little or no concern for them as individual beings. Efficiency and economy, therefore, were the goals in institutional care. Minimum custodial care at minimum cost dictated a preference for large institutions and large wards. In order to handle more patients with fewer attendants, the inmates had to be crammed into large, relatively bare spaces. These masses of idle, untrained inmates posed management problems and were often handled with callous and crude indifference.

Today we accept the retarded as fellow human beings, who, as we do, experience hope and fear, love and hate, pain and pleasure. Years ago it was commonly believed that the retarded did not really mind the crowded, monotonous, often repellent living conditions.

It was believed that mental retardates, particularly the profound cases, would not live long anyway, so why waste money on medical care for them.

Today we know that intelligence is not fixed, that it may be increased in an enriched environment. Under the old philosophy, when no improvement was expected, and little or no stimulation or training was given, little or no improvement and often regression occurred.

We no longer tolerate the old philosophy. Once we learn to think of the mentally retarded as genuinely human and individual, it becomes natural to ask, "How can we help him learn as much as he is capable of learning". The institution can no longer justify itself by merely existing; its new objective must be the maximum growth and development of <u>each</u> individual in its care.

Unfortunately, despite our new concepts, we must still contend with the legacy of the old philosophy. For the old philosophy was cast into steel and concrete, and it survives in most of our existing buildings. Mental retardates still live, eat, play, and go to classes in buildings which reflect archaic and now discredited ideas.

If individual growth and development is the prime objective of today's program for the mentally retarded, then all training of personnel, and all remodeling or replacing of buildings, should be governed by one consideration: the creating of conditions under which mentally retarded persons can learn best. This means a small family-like group in a small home-like unit. Why?

We know today that "lack of adequate care, stimulation, and motivation" can cause retardation even in a potentially perfectly normal child. <u>Every child</u> needs frequent close interaction with a normal adult to develop socially and mentally. <u>Every child</u> needs adequate care and personalized attention if he is to reach out and explore the world about him and develop meaningful relationships with other children. Learning to explore, learning how to play, how to handle objects and relate to people -- these skills are absolutely necessary to growth and development.

Major and continuing stress, such as anxiety, fear, or physical discomfort, may retard any child's mastery of his physical and social environment. The child who is a victim of severe neglect is slow to develop language. Without language skills, the child is not only hampered in mastering his environment, but he is almost certainly going to be retarded in developing what we call reasoning.

For all these reasons, the mentally retarded child, too, needs a circle of security -- of warm, continuing relationships, familiar faces around him, a feeling of personal ties and "mine-ness" in his immediate environment. But he needs this even more than the normal child, for his mind cannot grasp as large a group, nor comprehend as large an area. If he is forced to live as part of a large group, in a bewilderingly large environment, he will sometimes protect himself by withdrawal -- which reduces his learning opportunities.

The smaller group makes it easier for the attendants of an institution to provide personal relationships all children need. They come to see a small group, more closely dependent upon them, as individuals. They take more pride in progress, feel more concern for individual discomfort or unhappiness. There is more interaction between the adults and the children, particularly in the important area of speech.

The difference is perhaps more crucial with children, but the advantages of small-group living is also extended to adolescents and adults. It is easier for the residents to learn; it is easier for the attendants to be concerned about individual growth and development and individual welfare.

Today, efficiency consists in getting the highest quality of interaction, the best attitudes and practices, from a given number of attendants, and this

kind of fostering relationship develops much more easily in small units than in large groups.

Some people still favor larger buildings and larger wards under the mistaken impression that such construction is cheaper per resident. Architects agree that, because of the lighter construction permitted in small units and other savings, small units naturally lend themselves to the two types of construction cost about the same per resident or less for the smaller unit.

The smaller facilities, with lower overhead and greater reinforcement from existing community organizations and agencies, volunteers, and part-time professional help, can provide services at a comparable cost or at less cost than the large State institution.

The philosophy behind the program of care for the retarded must shape; it must shape, or be limited by the public's attitude. The communities and affected families must be re-educated, must become more accepting and understanding. The ideal for the future is to keep the child in the home, if possible, reinforcing the family as necessary with professional help and the array of supporting community services. If the child cannot be cared for and properly trained in the home, then he could live in the community residential center. Institutionalization in existing remnants of the larger but greatly improved State facilities should be reserved for those individuals with severe problems of retardation in growth and development, to those, who, because of their special problems, could not live at home or be cared for in the community residential centers.

Tomorrow we may have learned enough and have educated our communities to the point that we all will look back and wonder why today, in our uncertainties, we defended keeping any part of these remnants of the past.

A Working Conference on Residential Care was held the 13th and 14th of June at the University of Hartford in Hartford, Connecticut. Although time does not permit the most cursory review of the research findings presented, conclusions drawn from this carefully documented research study definitely shows that the quality of residential care is affected by the architecture and size of the facilities, and the staff attitudes. You may examine the study in detail in the Fourth Edition of Dr. Sarason's book, "Psychological Problems in Mental Deficiency", which will be published during the winter of 1968-69.

Researchers concluded that institutions differ in their effectiveness as to what they do to those in residence:

1. The most important single factor in improving programs for the better is size, size of the total institution, size of the units into which the total institution is broken.

2. The quality of supervision is another key in inprovement.

3. Happiness and unhappiness in retarded persons can be measured and has a direct relationship to how he is treated.

4. Unfortunately, administrative structure frequently stays tied back to the founding set-up and negatively affects program change for betterment.

5. Aides and attendants do what you make them do (supervize them into doing). What they do often has little relationship to the formal training they receive.

6. Staff size is no measure of institutional effectiveness.

7. Most of the needed changes do not take money. Failure to get additional funds is not always a detriment to providing program improvement.

The Dean of the University, in summarizing the conference, pointed out the Federal government is gravely concerned about the gap between knowledge and practice. The Federal government is interested in supporting programs of implementation. Implementation depends chiefly on dedicated leadership. Strong pleas were made for small specialized institutions; for closing the gap between knowledge and practice; for us all becoming more concerned with what happens to residents in the institutions; for closing the tremendous gulf between the superintendents' expression of what happens in their institutions and what is happening. The concensus of the conference was that we need to move now and not wait, for more money, for more staff, etc. Individual people have individual needs. As a group, we professionals spend too much time with concerns about labelling and too little in meeting the needs of those in our care.

In a March, 1968, PCMR message, Mrs. Hubert Humphrey pleads for the creation in institutions of as normal a living pattern as possible -- for small, attractive, home-like units located near the homes from which the residents come. She suggests it might be cheaper in the end if we could just bulldoze the old institutions down. Other members of the President's Committee on Mental Retardation, in the same message, plead for recognition of the mentally retarded as human beings with the rights basic to all mankind.

Our society is presently making major efforts to "normalize" and re-integrate many kinds of deviants. We, as an organization which played so strong a role in spawning the past, should dedicate ourselves to giving leadership and idealism toward a new tomorrow.

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V

The Educational Roles of a Residential Center

Mr. David Rosen

Before an educational program can begin, awareness of the administration and staff's philosophy must be promulgated among all employees, the parents and the community. Public awareness in an institution is a continuing responsibility of each department and its components. The creation and maintenance of public awareness and interest will play an essential role in the rapid growth and development of a residential school's program. The most important tenets of good public relations program are integrity and communication. In an institution, the promulgation of this philosophy must be initiated first with employees and parents; the primary objective of this effort is to develop confidence in the administration and to solicit the endorsement of the institution's goals and objectives. Employees and parents must be made aware of the limitations and potentials of the institution's program. They must be alerted to the administrations efforts, priorities and timetables in introducing new programs and in overcoming problem areas. The attainment of these objectives with parents can be accomplished by utilizing two means of contact and communication. Parent orientation prior to admission provides a means for the administration to disseminate general and specific information; it is an appropriate setting in which to answer questions. This exchange tends to set the tone, develop the climate, advance the philosophy, develop confidence and awareness and allay apprehension concerining residential placement. If a parent association does not exist, one should be established. A council, comprised of parent representatives of each of the cottages should meet monthly with the superintendent and representatives of his staff to discuss topics of mutual interest and concern. General meetings for all parents should be held at least every other month. Sufficient programs for these meetings should be provided by the school department personnel, describing their particular impact on the total program. This dynamic relationship can

result in an empathic rapport being developed between institutional personnel and the parent population. Parent support, as a result of this effort, can result in a deep interest in the welfare of employees and promotes their well-being through institution of appropriate action. Employees must be constantly informed of changes, improvements and objectives in order that they may function more effectively. In most institutions, they undergo an initial orientation session prior to assuming their duties. Orientation should deal with the general areas of operation and the prevailing philosophy of the institution. It is vital that employees remain in the mainstream of the school's communication system; not only for the purpose of being well informed to better carry out their responsibilities, but also because their attitude and pride in the institution are reflected in the community. Public relations, like charity, begins at home. Communication within the school campus can be accomplished by staff and departmental meetings; by employee organizations, whose formation should be encouraged by the administration; by bulletins, memos, departmental news, notes and the school newspaper. The effectiveness of this effort will be exemplified by employee performance during curisis situations such as snowstorms and civil disturbances.

Concomitant to the development of awareness among parents and employees is the development of awareness in the community. Visits of local, state and federal officials as well as county and state parent associations, service clubs, philanthropic organizations, students and volunteer groups should be encouraged. Scuh visits results in increased public awareness of the problems mental retardation present to varied disciplines and form a base for collaboration with public and private agencies. Such collaboration has the common goal of improving services for the retarded and leads to the direct involvement of citizens at large to widespread participation in retardation programs. Following visits, public and service clubs invariably indicate a desir to help the residents. This desire has two general manifestations. Direct offers of individual or group volunteer assistance and offers of financial or other tangible

contributions. It is obvious that there are innumberable available assignments for community volunteers which directly or indirectly provide services to the residents. Direct patient care, including feeding, recreation, sense stimulation, parties and dances, add to the fullness and variety of the residents' daily life. Public awareness created by direct contact is advantageous and easily recognized. More subtle but equally valuable is the communications established with those in the area who are not directly involved. These people though contact with or knowledge of the many groups and individual volunteers can develop and awareness that the institution exists followed by an understanding of the school and its purpose.

Affilations with colleges and universities develop public and professional awareness. These associations can be established by encouraging visitation and by conducting institutes dealing with various professions servicing the mentally retarded. Affiliations of this nature usually result in staff members instructing courses at nearby colleges and universities and serving as consultants to local, state and federal agencies.

The solicitation of area school music groups and professional and amateur performers to present programs for the residents has many benefits, in addition to the pleasure derivied by the residents, people performing are made aware of the school's population and purposes.

All items of special interest that occur relative to the school should be submitted to daily and weekly newspapers in the area. Newsworthy information of particular disciplines should be published in professional journals and publications. The mentally retarded, particularly the institutionalized retarded, are a strange and, sometimes frightening, enigma to a large segment of the public. The printed and spoken word, the firsthand view, word of mouth passage are all means of communication. The effort expended in sending the message abroad is returned tenfold to the institution in the form of morale, interest and support. Properly nurtured, it matures, flourishes, and may even blossom into acceptance and understanding of budgetary needs to provide increased and more sophisticated services to the mentally

retarded.

It is important that liberal visitation and vacation regulations be developed, that parents be informed, be encouraged to offer suggestion and criticism, to establish rapport of institutional personnel and to maintain themselves in an atmosphere of welcome and warmth. Trauma of residential placement and the ensuing emotional difficulties are alleviated in such a setting. In this environment the parents and relatives can serve as so many more additional supervisors and more frequently be supporters as well. In this kind of environment their concern for their handicapped member tends to manifest itself in a positive, constructive view of the school's efforts. Communications with parents should always be open. A large percentage of admissions that come into institutions come from communities where services were often nonexistent, difficult to come by, prohibitive in cost, and presented scheduling and transportation problems. All too often as a result, no treatment was provided during the vital formative years. Frequently parents were not encouraged to assume an active role in developing and implementing a regular regimen with their child. A lack of treatment often produces conditions which are difficult to correct and far easier to prevent. The institution has the opportunity of having under one roof a combination of evaluation, treatment, training and therapy services which are not often found in the community. There is the recognition from the public that residential placement may present an opportunity for growth and improvement. The type of professional services, ancillary services, the effectiveness of a team approach encompassing all facets of daily living, the availability and use of space and personnel on a continuous basis, may well implement the hope and aspiration of parents. We are prone to speak of institutionalization as a last resort, as a denial of so much that is worthy and irreplaceable that the existence of something which may well be more meaningful and provide a greater service is too often ignored. There can be considerable satisfaction among the parent population of the residential school as progress is made by residents in ambulation, toilet training, feeding, social development, increased awareness and appreciation of the people and setting about them, in an ability to adapt and

to participate. For parents, small progress is large news. For parents of severely mentally retarded children, any progress is amazing and in most cases unexpected. Include the parents as valued members of the team. Professional sanctity often eliminates the parent completely. Years of contact between parent and child are negat by the mere fact of not being professionally based. At each institution, the desire to communicate with and inform should be paramount. What we do, what we cannot do, what our expectations are, what the future may hold, all are open to public disseminat and discussion. It is my view that is is better to know than not to know, it is bette to say we cannot than to raise false hopes, it is better to try than say it is not possible. It is better because it is right. It is right because the doing may reliev pain, it may widen a narrow vista, it may move and raise a child to a sitting or standing position and it may stimulate a dormant mind. For the retarded and for their parents, our capacity to serve and our skill in serving means the difference between hope and despair, between total dependence and a degree of self sufficiency. It shoul be our intention to bring today's skills to problems and handicaps that have been wait ing much too long.

Most authorities recognize the tri-parted plan of treatment, training and therapy is vital for the growth of retarded children. Nevertheless, there are unfortunately too many residents excluded from formal institutional programs. Similarly, it is regrettable that a considerable percentage of the retarded are still barred from publi school instruction. During the formative years diversified activities are necessary to develop intellectual functioning, social behavior, muscular co-ordination and motivational attitudes. Case histories have demonstrated that retarded children tend to be stunted by frustration and privation. Therefore, to achieve higher degrees of intellecutal, social, emotional, and physical maturity, a program offering a wide variety of experiences must be presented during childhood and adolescence. One of the policy statements on residential care adopted by the board of directors of the national association for retarded children in October, 1968, states that large numbers of children in residential facilities for the retarded are deprived of the

education rights guaranteed all other children. The policy of N.A.R.C. asserts that the regular public education agency should have the responsiblity for the education of the mentally retarded who are in residential care. Furthermore, the same standards of certification should apply to all teachers whether employed in the residential center or the public school. For those retarded with potential for return to the community, serious consideration should be given to providing their education with their community peers. There are those of us enaged in working with the retarded who believe that with appropriate program, even the mentally retarded who are grossly physically handicapped can profit from such training. I am sure that you are aware that almost any institution you may visit can usually exhibit a number of fine examples of individuals who prior to receiving training and therapy were complete bed patients. Is it that the severe, the profound and the multihandicapped cannot benefit from programs presented by certificated teachers or is that the teacher has not been prepared in our institutions of higher learning to cope with the needs of this perpetually increasing segment of our institutional population? Can we justifiably ostracize children and adults from educational programs because our existing services and facilities are not patterned to meet their needs? The residents are our primary concern. Accordingly we must alter our programs to fit the requirements of all residents rather than merely adapt the residents to the rigid exigencies of the program. As educators, can we rationally terminate our professional services below a particular I.Q. or M.A. boundary? Are we then in essence professing an incapability to teach or train, or are we implying that certain human beings are simply not worth the effort? If members of the medical professions assumed this attitude, would they proceed to restrict treatment and hence stockpile patients who have a life expectancy of not more than one year or perhaps five or ten years? We in education must not and cannot accept this concept. Its validity is negated by the numerous excellent examples of the professional teacher creating dramatically successful programs with the severe and profound. At present it is true that not all institutions are financially able to provide sufficient well prepared certificated teacher for all the severe and profound who can benefit from such

instruction. However, all institutions have adequate funds to evolve a force of teacher aides who are qualified to teach and train the severe and profound under the guidance of a master teacher.

In the state of Washington to satisfy the demand for teacher and program aides, a program is being spearheaded jointly by institutional superintendents and community college administrators. The outlined proposal is aimed at providing college training to all qualified attendant personnel. In pursuit of this goal, all attendants at Lakeland Village will receive an eight week training course with college credit. The accompanying fees are underwritten by the institution through its federal in-service training grant. Additional classes taken by the attendants at their own expense will be offered for a one year certificate and for an associate of arts degree with a two year training period. A survey at Lakeland revealed that fifty percent of the non-professional staff not only indicated their desire to participate in the program but also to augment their initial instruction with matriculation at a four year college. Employees who successfully complete the educational stipulations will receive titles and salaries commensurate with their educational training. Now at Lakeland Village it is contemplated that of the 150 employees hired during the next biennium 130 will be program or teachers' aides.

Another example of a successful comprehensive program offering services to all residents regardless of the severity of their handicap is found at Woodbridge School in Woodbridge, New Jersey. This ambitious program is undertaken in eighteen cottages, each of which contains a therapy schoolroom. Ninety-five percent of the residents are severely and profoundly retarded, fifty percent are non-ambulatory. At Woodbridge a certified teacher is assigned to each cottage guided by interdisciplinary reports. She has evaluated each of the approximately fifty residents in the cottage in order to structure the program to meet individual needs. Each teacher is assisted by two aides who have received special training. Periodic training periods and workshops in addition to supervised on the job training have been planned to increase the sophistication of the teachers and aides assigned to implement this program.

As a supplementary preparation for the multiplicities of training required by the physically handicapped, teachers and aides were enrolled in an intensive month long formal training program at a nearby physical habilitation center. The activities in the non-ambulatory cottages are under the direction of a supervisor of instruction, physiatrist, and apphysical therapist. Physical habilitation and rehabilitation, prescriptions and consultations following individual evaluations are forwarded directly to the teacher by the physiatrist. As the program progressed, prosthetic devices were purchased as required. Orthopedic surgery has also been planned for those children who can benefit from the procedure. Correction achieved by surgery is followed by physical rehabilitation activites to maintain the gains afforded by surgery and to complete the habilitation of the residents. A schedule for the residents in the non-ambulatory cottages include physical habilitation, physical rehabilitation, occupational therapy, and all other aspects of training related to activities of daily living. The latter include speech training, sense training, self-help, social relationships and academic training, pending on indications of its value. In the ambulatory cottages under the direction of a supervisor of instruction, different techniques which stimulate the resident's mind and body are exercised by the teacher and the program aide. During the period when the teacher is furnishing formal instruction in the cottage classroom, the aide provides ancillary training to those children not scheduled for formal classroom activity at that time. Each aid is well disciplined in the practices required to sustain a daily all inclusive program of self-help, sense training, arts and crafts, music, sports, games, field trips and supervised social activities on a group and individual basis. The program in both the non-ambulatory and ambulatory cottages has reached its pinnacle of success largely because the attendants assigned to the cottage now contribute to the treatment, training and therapy program during the normal work day. All attendants through the efforts of the cottage life administrative staff and the professional teacher assigned to the cottage realize their role as essential contributors to the growth and development of each resident. To develop this relationship attendants are continually encouraged to attend and to participate in many of the

residents' recreation and education activities conducted in facilities outside the cottage. These additional programs for the cottage involve a daily schedule of activities at one of the five major playgrounds in the multi-purpose building or in the activities and training center. All activities are appropriate to the residents' physical and mental functioning level. They include one hour of active games, one hour of passive games, and one hour of arts and crafts. Residents with more interest and ability are assigned to advanced arts and crafts and music groups which supplement the regular training schedule. Large numbers of residents have been tested and evaluated for speech competence by the speech and hearing teacher. Individual therapy for those in need is given by the specialized teacher. This corrective training is amplified by planned speech instruction and training provided by classroom teachers, aides, recreational assistants and cottage personnel. The school's classification committee composed of representatives of the psychological department, medical department, education department, cottage life department and social service department convene regularly to evaluate the resident's progress. The teacher and cottage supervisor are present at these meetings to contribute to the proceedings and to profit from them. Recommendations following this assessment are implemented by the appropriate departments. To illustrate the education and training program that was developed at Woodbridge for the most handicapped segment of its population, 500 severely and profoundly retarded and multiply handicapped children, I would like to show the following slides which were presented at the A.A.M.D. conference last year at Boston.

I would like to take this opportunity to discuss vocational programs. I hope we all agree that all residents should participate in education and training programs designed to meet their specific needs and to raise them to their highest potential. The areas of education and training for each individual are determined by interest, abilities, previous experience and present and future needs. For some, the program is planned in preparation for community living; for others, it is planned for optimum adjustment to institutional living. Whatever the specific purpose, the general aim of all programs is to provide experience which will enable each resident to become

a more efficient member of the social group in which he lives. I am not one who believes that special workshops should be established within an institution. An appropriately planned vocational training program within an institutional setting contains sufficient and varied work stations for all but the most severely retarded residents. The workshop programs that I have seen for the severe and profound are glorified crafts programs with no more of an objective than keeping the child gainfully occupied. With patience, fortitude and ingenuity, a vocational program can be developed for these people which can make them contributors to the institution's economy. They can derive satisfaction from participating in household chores, such as cleaning the dormitories, stacking trays, making beds, etc. The important factor, however, is to see that they are appropriately trained and supervised by someone whose main responsiblity is this facet to the program, and not an attendant who is not trained nor has the time to develop those qualities in the resident required for the various tasks.

An appropriate vocational program cannot be equated through a straight work assignment. The word training intonates that following a given period an individual will be able to accept certain responsiblities. How many residents in institutions have been on so-called vocational training programs for ten or even 15 or 20 years? a vocational assignment is <u>not</u> vocational training. After a period of time without pay, it is slave labor. Training must be sequential and lead to paid employment. The major objective of any school program is preparation for life in the family, the community or the institution. Consequently, there are many aspects of the curriculum other than direct training and experience which contribute to the resident's preparation for occupational adjustment. Since preparation for employment is considered only one of several major objectives, formal classroom instruction should be provided which interrelates the various other objectives. Therefore, in addition to providing training in vocational skills, the curriculum should include teaching units on health, safety, social development and adjustment, personal grooming, family and community living and occupational information and requirements. These areas should be formally

presented in the academic school, in adult education classes and specific orientation classes. The resident in the vocational programs should not be excluded from recreation, arts and crafts, music, religious services and ancillary programs which can be beneficial. Through an integrated training program, a resident may become a contributing member of society in the institution or in the community. Occupational training should be designed to give the residents real life work experience in a variety of vocational assignments within the institution. Full-time occupational training assignments, except in the summer, should be made when residents reach age 18. However, if at that time academic potential has not been fulfilled, residents should continue academic training on at least a half-day basis. Full-time school children, mentally and physically capable, should receive occupational experiences. Emphasis should be placed on the development of good work habits, attitudes and behaviors relevant to vocational adjustment, rather than on the mere acquisition of specific vocational skills. Work study programs provide an excellent opportunity for the exploration of incentives and attitudes in relationship to employment. It also creates an additional opportunity for the further development of occupational information and desirable job attitudes and increases the ability to adapt to new situations. Residents' job experiences should be utilized to supplement classroom instruction. All aspects of the program - placement, discipline and evaluation - should be under the direct supervision of the vocational supervisor and his staff. Guidance and supervision should also be provided by the vocational department, in conjuction with employees in the area to which the resident is assigned. Every attempt must be made to place a resident worker in an assignement compatible with his degree of retardation, physical condition and personality. In addition, assignments should be reviewed at the request of a particular department, the work area supervisor or the resident worker himself. Changes should be made in the best interest of the worker. In some instances, an assignment may be changed to give the resident a change to experience adjustment to a new situation or simply to provide a change of routine. In no case should an assignment be considered permanent. The occupational training

program should be very carefully structured in regard to hours worked, days off and working conditions. Rules and regulations supporting rights and priviliges must be comprehensively defined and strictly enforced. Full precautionary measures should be taken to minimize the chance of a resident's being exploited. Particular attention should be given to workers of advancing years or with physical handicaps. Special assignments should be tailored to the abilities and needs of these workers, and if this is not possible, they should be released from the program entirely. Stable workers should be rewarded by placement on a resident wage program which provides remuneration for each day of work. This money should be credited to the worker's account and may be used at his discretion. All residents participating in the occupational training program must be evaluated periodically in terms of work efficiency. Each worker should be rated jointly by the vocational department and the work area supervisor.

Following the successful completion of a vocational training program, if we believe that the mentally retarded are employable, provisions should be made within the organizational structure of each institution to permit the employment of those residents who have successfully completed the vocational training program.

In New Jersey institutions, and recently in Washington, and in at least one other state, a formalized program to hire the retarded has been promulgated. I would like to describe this program for you and also another interesting program that began in New Jersey about a year and a half ago at the Woodbridge State School, in which the retarded from the community were trained at the institution and later employed.

The institutional aide program, in New Jersey and in the state of Washington, for the employment of residents who make outstanding progress in the vocational training program and who have participated in coordinated education training programs and who appear to be candidates for release, may be appointed to the insitutional aid program. This appointment is made through the social service department,

after consulation with other staff members. When appointed, the aide is placed on the institution's payroll and provided with a special uniform. The aides' starting salary, in New Jersey, is $100 per month with two increments of $100 each. In Washington, the resident starts at $60 per month with an increase of $20 per month for each of the following two years. In the initial program it was agreed that a resident should not be on the program in excess of three years.

The institutional aide program is planned to develop the resident's abilities so that he will eventually function independently of sheltering and supporting services. Every attempt is made to help him become self-sufficient in the community, but the institution continues to provide needed guidance and support. It is felt that this is necessary in order that the change in social status does not adversely affect the aides, the residents or the employees. When it is deemed necessary, counseling is provided by social service, psychology, vocational and cottage-life departments. Supervision and control are consistent with the practices applied to the care of residents on conditional discharge in the community, since the status of the aides is technically considered to be conditional discharge. The aides, therefore, may be formally discharged on the successful completion of the program in a period not to exceed three years.

After discharge, the institution may desire to hire the aide as a full employee. Should this be the case, the aide retains the option of accepting the position in the institution or of seeking employment, with assistance of the institution, in the community. In one institution alone, in New Jersey (The Vineland State School), approximately 100 of these residents have been employed at the facility.

To augment the program, orientation classes are established for all institutional aides. Careful consideration is given to the work skills and attitudes taught by the work area employees. The vocational department coordiantes this information with the subject matter areas in order that optimum benefits are received by the aide. Material presented in this class is a review of the objectives and subject matter of the adult education classes. In addition, it includes orientation

information, experience in community living and appropriate field trips. Class attendance is mandatory for a three month period and thereafter on a voluntary basis.

Another unique occupational program was the development of Project Workout, which originated at the Woodbridge State School as a community service. I initially suggested this program to the then director of the New Jersey rehabilitation commission, Mrs. Beatrice Holderman; it was then submitted to the U.S. Department of Labor, Bureau of Apprenticeship and Training. It was accepted and put into operation on November 13, 1967. $156,000.00 was allocated for this project over a two year period through the coordinated efforts of the U.S. department of labor, in conjunction with the bureau of Apprenticeship and Training, M.D.T.A. Act of 1962, PL 87415 and the New Jersey rehabilitation commission. The program provided for a project director, a project supervisior and five teaching assistants. Trainees for Workout are selected and screened by the New Jersey rehabilitation commission. Upon completion of this evaluation and certification of the prospective trainee's suitability and readiness for training, referral is made to the Woodbridge State School for an interview and final determination of acceptance. The candidates are accepted on the basis of ability of benefit from training and ability to perform the duties of the job upon completion of training. This judgment is based on all available information about the candidates, including past performance in training programs, schools and workshops or other experiences which require similar physical or mental ability and appropriate psychological and medical examinations, in addition to those criteria used by the rehabilitation commission. The counselors from the commission assume the primary responsibility for receiving referrals from other agencies and individuals, in addition to screening and evaluating each candidate's suitability for training. The counselors maintain contact with the trainees and with Woodbridge State School to provide such ancillary services as may be required. The trainees range in age from 17½ to 30. The vocational areas chosen as training grounds for Workout are resident care and housekeeping. It is felt that these areas offer a

multitude of work situtations in which the mildly retarded can function and where job opportunities are plentiful. The successful completion of these training programs will lead to a civil service career for the graduates. These civil service positions are secure, and the salaries are higher than most retarded persons can earn in the community. There are pension benefits and a desireable holiday and vacation plan.

The training course runs for a period of 30 weeks, with the possibility of extension if necessary. The length of training each candidate receives is determined by his performance progress. A record of each trainee's progress is kept on a series of weekly classroom and on-the-job progress reports, which are submitted to the project director. However, if a trainee shows evidence of a thorough knowledge of all the required skills prior to the end of the 30 week session, he may be immediately employed. The trainees are instructed in the proper techniques and skills necessary to qualify them for the position of institutional attendant. The program allows for flexibility in the teaching methods in order to enable the trainee to receive immediate assistance from the teacher and to meet individual needs of the students. A stipend of $20, provided by the MDT Act of 1962, is paid weekly to trainees between the ages 17½ and 21 years, while the individuals are in training. The uniforms are issued and are to be worn daily, one of which is provided for the trainees by the project. There will be a total of 75 trainees over a two year period. Twenty-five have been scheduled to participate in each of the three 30 week training periods. It is possible in this program to provide teansfer of learning and immediate positive reinforcements of the subject matter learned in class. This carryover builds self-confidence on the part of the trainees as well as providing a sense of security. For example, the trainees are taught in class how to recognize many kinds of ailments that might affect the resident, such as rashes, bruises, swellings, etc. The trainees are then taken to the cottages and required to perform daily routine body checks on residents in order to become proficient in spotting such problems. This type of learning situation is possible because there is a teaching assistant assigned to each five trainees. This teaching assistant actually assists the teacher in the

classroom and then, acting as a supervisor, takes his group of five trainees out on the job. This is especially significant to the project, since one of the greatest problems encountered in programs of this kind is lack of communication and coordination between classroom instruction and on-the-job experience. This workout project is unique in still another way; all trainees who successfully complete the program are guaranteed a civil service position.

The U.S. Department of Labor has indicated that this is the first project of this kind that they have ever funded. Before the actual training program began, the project supervisor and the five teaching assistants worked as institutional attendants in both an ambulatory and non-ambulatory cottage in order to refresh their knowledge of the job and reacquaint themselves with current practices. Since, before one can expect to teach others, he must first be well acquainted with the job himself.

During the 30 week training period, trainees perform their on-the-job training in eight different cottages, four ambulatory and four non-ambulatory. In this way the trainee obtains experiences in dealing with the various problems associated with mental retardation. Since their experience will vary from cottage to cottage, they should be more readily able to adapt to the cottage environment in which they are placed when they become insitutional attendants, and thereby will gain the experience necessary to enable them to work successfully regardless of the cottage in which they are placed.

A Workout Project advisory committee was established to devise a practical vocational training manual, as well as to assist in the development and implementation of the on-the-job training portion of the project. The committee was made up of the project director, the project supervisor and the senior teaching assistant from the Workout Project, six head cottage training supervisors from the cottage life department, the coordinator of the in-service training department, the director of nurses from the medical department, and head institutional housekeeper, as well

as senior clerk for recording purposes.

The success of this program is illustrated by the fact that over 30 of these individuals have already been employed by the institution. The two aforementioned programs are just a few illustrations of some of the many successful vocational projects being sponsored by insitutions in this sector of the United States. Fortunate is the institution that has a sufficiently large employee work force that they do not have to depend on the residents to complete the tasks and the chores of the instituion. The many successful day work placement programs that are being carried out by many institutions could be expanded and sophisticated so that we could remove from our institutional populations all of the mildly r[illegible]rded. Isn't it a shame, in this day and age, that mandatory appropriate education programs for the mild and moderately retarded do not exist in all of our States? In this day and age we should be considereing mandatory services for the severe and profound in our communities!

A word about recreation. An education program should begin and end with recreation. In an institution, with its wider scope, recreation is a screening area for the admission of residents into formal school program. It is a social development program: A program which makes activities available for all levels and conditions associated with the retarded. It is an excellent medium to develop appropriate social attitudes, coordination, dexterity and muscular development, and finally, an area for enjoyment and use of leisure time. With the increase in institutional staff, with Title I, is there any excuse, other than poor management, why custodial programs should continue?

In conclusion, I'd like to make some remarks about what I feel is the role of the director of education in an institutional facility. At best, it is a role that is quite complex. Close interrelationship between all of the departments in the institution make it imperative that the director have a thorough understanding of the functions, aims and problems of each department in the entire institution. He should

be responsible for all educational training, vocational and recreational activity. He must foster good relationships and establish coordination between the personnel in the cottages and in all departments. He must make a distinct effort to communicate and sell his program. He can learn much by utilizing the methods and procedures of industry and commerce in developing acceptance of goals and objectives.

In most facilities the equipment and number of personnel available are far from adequate. He must be able to improvise with the conditions and equipment at hand. He must have the ability to visualize many ways whereby every possible facility is utilized to the utmost. The other members of the staff should be aghast at his suggestions but should admire his resourcefulness and, because of previous successes, give him their wholehearted cooperation. The director should set high goals for his department; he should expect each resident to be given an opportunity to receive training and education which will enable him to develop to the limit of his capabilities. He should stress the use of every possible facility to enrich the lives of the residents in every possible area of learning. His policy must be to place the welfare of the children above the convenience of an employee. It is his hope that the institution would be so well administered that each resident will show some regret if and when he is placed. Directors of education must play a very strong role in leadership, in directions that will lead to the ultimate goals desired for the residents.

The director should pave the way for all supervisors and teachers to use their individual knowledge, ability and ingenuity for the best possible development of the residents. He should recognize and acknowledge the achievements of all members of his staff. He should be loyal to the personnel in his department. He should always be ready to support all supervisors and teachers in all matters and philosophies that have been agreed upon even though strong opposition may be expressed by members of other departments. He must always give his wholehearted support to his super-

visors and teachers in enforcing the rules and regulations of the instituion. Likewise, he should be depended upon to come to the defense of his staff to provide better instruction. He should coordinate programs that will be advantageous to his teachers. He should aid and encourage the development of all necessary courses of study and curriculum. He should hold regular meetings with the supervisors of the education department to visualize future needs and to formulate plans whereby steps may be taken to provide for such needs. He must keep all personnel informed concerning all changes of policy as determined by the central department and by his own administration. Any matters of policy pertaining solely to the education department should be determined by the director of education, with the aid of his supervisors and the sanction of the superintendent. He plays a very important role in respect to public relations. He must be capable of creating public interest in and greater understanding of the mentally retarded who are residents at his school. He should, through proper channels, send items of public interest to the local newspaper. He should welcome every opportunity to explain the opportunities his institution provides for training, education, recreation and vocation. He probably will have to give up many comfortable evenings at home to talk before groups interested in the field of mental retardation in general and in his institution in particular. He should be strongly in favor of exhibiting the patients' educational work and handicrafts at all public events and at colleges and wherever else it might prove beneficial in creating better public relations.

The director of education of a good program will be requested to act as a consultant to teachers' college and to professional groups; he will be sought after for advice from parents and lay groups. He should, if he does not already have it, develop a weekly bulletin; pertinent school information for all institutional personnel should be included in the bulletin. It should include comments of interest to all employees. It should be distributed to each teacher, each building and to each department in the entire institution. He should make an honest effort to aid each

member of his staff in attaining added professional growth. It is his obligation to conduct a current in-service training program for the members of his department. He should make special arrangements for them to further their education on both graduate and undergraduate levels. He should enlarge the professional library of the education department. He should bring to the attention of the staff various publications that are of importance to the field of mental retardation. He should extend the horizons of the teachers through scheduled visits to other institutions and to exhibits related to their field of work. He should make every effort to build up school spirit. Each staff member should be encouraged to participate in work plans as well as social activities. Each should be encouraged to join and participate in professional organizations directly related to mental retardation, both on an institutional and on a public school level. Membership should be encouraged in other associations that provide for the advancement of education and teaching. He should encourage his staff to participate in the establishment and serve in institutional in-service training programs, and very improtant, he should dismiss any staff member who remains inefficient after all means of guidance and instruction have failed. If he has been successful, a custodial program will not exist at his facility.

VI

Educational Assessment and Placement

Dr. Margaret Jo Shepherd

Educational programs for the mentally retarded are now, and will continue to be, significantly influenced by altered attitudes toward the nature of diagnosis and educational decision-making. Concepts and techniques of diagnosis based on a determination of etiology and the measurement of behavior for purposes of classification and prediction have been augmented by diagnostic concepts and techniques which stress definitive assessment of the manner in which an individual interacts with his environment. The result is a qualitative description of individual status and performance with respect to behavioral variables related to learning and achievement in an educational setting. While a traditional etiological and classificatory orientation to diagnosis retains utility for specific purposes, educators and psychologists have become increasingly sensitive to the limitations of this diagnostic orientation for educational planning. Special Educators require descriptive, individualized information regarding the behavioral consequences of mental retardation in addition to medical and psychometric data revealing the cause and degree of retardation. Emphasis must be placed on the assessment of learner characteristics rather than the more limited, from an educational standpoint, practice of diagnosis.

The educational consequence of an assessment orientation which stresses individual behavioral analysis and description with emphasis on individual learning style and performance patterns is a rather radical alteration in the base for educational decision-making. Major educational decisions can be made on the basis of data specific to the learner and directly relevant to the

educational program rather than overly general and marginally relevant diagnostic information such as that represented by the intelligence quotient and the classificatory labels, "educable" and "trainable". If a teacher knows a child in terms of specific assets and deficits in preceptual-motor, language and cognitive skills, in terms of the nature of his response to re-enforcement, in terms of the specific skills he has acquired through training and in terms of the relationship between his performance and task structure, then this data becomes the basis for making decisions regarding specific educational objectives, educational placement, grouping and instructional methods and materials. The result is truly individualized educational planning and programing and Special Education achieves its real meaning and begins to fulfill its promise.

It is difficult to believe that the direction for Special Education which this qualitative assessment orientation provides would not be acknowledged and implemented in institutions for the mentally retarded. The philosophy and process is the same regardless of the degree of retardation or the nature or scope of the educational program. The technology in the form of new tests, new techniques for controlling and programing the educational environment can be adapted to any setting. The results of such an orientation can be observed and validated in relation to the education of children with specific learning disabilities.

Implementation, obviously, requires institutional support and administrative action. Institutional support depends largely upon a commitment to this particular philosophy of assessment and the recognition of the interdependence and interaction between assessment and educational planning. Legitimate administrative action would appear to derive, initially, from the study and selection

of assessment approaches and the organization of educational procedures and personnel into a pattern which facilitates the development of an effectively individualized educational program.

Commitment to a Philosophy of Assessment

The espoused philosophy of assessment recognizes that mentally retarded children present attenuated patterns of inter- and intra-individual differentiation and that extreme variation and variability characterize their behavior and performance. Educational programs which derive from considerations other than the individuality of the learner fail to achieve a precise match between learner and program and are, consequently, inefficient, and frequently ineffective. It is to individual behavior patterns that Special Education must respond rather than to inferred or hypothesized group characteristics. Individual behavior patterns can only be defined through intensive observation and study.

It is the implicit assumption of this philosophy of assessment that Special Education must be considered with the acquisition of skill and the development of potential, that it must always be positive and constructive and that it must view children not only in terms of deficits and dysfunctions but also in terms of assets and strengths. Special Education for the mentally retarded too long ago abandoned an achievement orientation. Educators' energy must be directed toward remediation and compensation regardless of the degree of retardation and the ultimate limits on achievement. Such a philosophic position demands that children be described in terms of what they can do, what they have learned, and under what conditions they can respond as well as in terms of specific behavioral deficits and achievement limitations. Diagnostic information must, therefore, be qualitative.

Finally, this assessment philosophy maintains that the only justifiable

reason for diagnosis is for the purpose of prescribing and providing treatment. This is as true for education as it is for medicine. Consequently information must be provided which is directly relevant to the procedures of educational treatment so that an educational prescription can be developed, implemented and evaluated on the basis of its effect on the individual. The educational treatment subsequently assumes the burden of ongoing diagnosis relative to its own effectiveness.

Institutions which acknowledge and respond to the new developments in psycho-educational assessment must, therefore, be commited to the philosophy that diagnosis should specifically prescribe educational treatment, that it should effect individualization of educational procedures and that it should re-establish a corrective and remedial orientation in the special education of the mentally retarded. Such philosophic commitment provides the basis for effective administrative action.

Assessment Approaches

Specific assessment approaches have evolved from psycho-educational diagnostic practice and special educational practices. Essentially there are four such approaches which are neither mutually exclusive nor irreconcilable. It is conceivable that all four could be utilized in any given institutional setting. The significant problem is the identification and definition of each of the assessment approaches and, ultimately, the selection of that approach which best fits the needs of a particular institution.

The first assessment approach is similar to the one which has been labeled the diagnostic-remedial approach by Bateman (1967) and which has been described, without being so titled, in the special education of the mentally retarded by Kirk (1966) and Smith (1968). This procedure incorporates a four-stage

assessment program. Assessment originates with a consideration of capacity for achievement which is determined through intellectual evaluation. It proceeds to a determination of current achievement status which, depending on the age and ability level of the child either involves standardized achievement testing or, for pre-academic students, the use of behavioral development scales similar to that constructed by Valett (1967).

Stage three involves a qualitative description of achievement characteristics and utilizes either diagnostic reading, math or spelling tests and, for pre-academic children, readiness tests and a descriptive analysis of the components of achievement evaluated in stage two. The final phase of assessment represents an intensive study of the perceptual, language and cognitive correlates of educational achievement and skill acquisition and results in an extensive examination of perceptual, perceptual-motor, language and cognitive functions to determine the nature of individual performance patterns and, subsequently, the relationship between these functions and achievement characteristics and capacity for achievement. An educational program is derived from this analysis of individual learning characteristics and achievement patterns which attempts to utilize learning strengths to foster achievement gains and which also attempts to correct, improve or compensate for learning deficits.

Specific assessment instruments such as The Illinois Test of Psycholinguistic Abilities, The Frostig Developmental Tests of Visual Perception, The Purdue Perceptual-Motor Survey and The Detroit Tests of Learning Aptitude are utilized in this final phase of assessment. Additionally, informal procedures designed to assess sensory learning processes, vocal and motor expressive functions, memory and sequential learning functions are utilized depending, again, on the age of the child, his current developmental status and the degree of in-

tellectual retardation.

The ultimate objective of this type of assessment with mentally retarded children is not to design an educational program which will cure the intellectual deficiency unless that deficiency represents an error in diagnosis as a consequence of specific remediable learning disabilities. Rather, the objective is to maximize the individuals ability to achieve relative to his own potential and to close the gap between potential and achievement which so often characterizes the performance of mentally retarded children.

A second approach to assessment is incorporated in the model of educational treatment which has come to be known as Behavior Modification and which was formulated from the principles and procedures of operant conditioning. Continuous assessment along specific behavioral dimensions is an integral component of this educational treatment procedure. Behavioral assessment of this type has been described by Lovitt (1967) and McCarthy and McCarthy (1969), is a specific component of the assessment schema developed by Quay (1967) and was translated into educational practice with the mentally retarded by Birnbrauer, Bijou, Wolf, Kidder and Tague (1965) among others.

Assessment of this type requires an analysis of the environmental antecedents to specific responses, the frequency of response occurence, the contingencies which evoke responses and which sustain response production. Frequently, assessment specifically defines the nature of an effective reinforcer and the ratio between the number of responses and the number of reinforcers which defines the most effective reinforcement schedule at any given time.

Contrasts and theoretical conflicts between this approach and the diagnostic-remedial approach are obvious. The diagnostic-remedial approach to assessment

relies on an analysis of inferred psychological correlates of observed behavior and a further set of inferences regarding the relationships between these psychological processes and educational achievement. Operant assessment is essentially a study of the relationship between environmental events and individual response patterns and response rates and as such is not based on inference but on observable events. Both approaches have advocates but the theoretical distinctions are so sharply drawn and the resultant educational treatments are frequently so different in emphasis that one approach is usually embraced and the other is excluded and, frequently, denounced.

Task analysis, the third approach to assessment, has features which overlap with operant assessment. Both are behavioristic in orientation and stress an analysis of educational deficits rather than learning disabilities. Both approaches are derived from Skinnerian theory and the educational derivative, programmed instruction. A distinction between the two assessment concepts may seem, initially, artificial. The operant approach, however, places primary emphasis on the relationship between overt behavior and reinforcement contingencies while a task-analytic approach places primary emphasis on a discrete analysis of the behavioral components of educational tasks and the appropriate design of learning sequences based on this analysis. Most educational assessment programs derived from behaviorist theories contain elements of both operant and task-analytic assessment procedures. Specific procedures do exist, however, which are singularly task-analytic in orientation (Connor and Talbot, 1966; Englemann, 1967; Hewett, 1968 and Shepherd, 1968).

Procedurally task-analytic assessment involves the selection of tasks to be learned, the re-statement of these tasks in terms of explicit, obser-

vable behaviors, a precise specification of the discrete behavioral components of the total task and the arrangement of these task components into a hierarchy beginning with single unit behaviors and moving systematically to more complex behaviors. Performance is then assessed in terms of the component behaviors which are present in the individual's immediate behavioral repertoire and those which have not yet been acquired. The results of this assessment are subsequently utilized as a basis for determining the starting point and the direction for instruction. The ultimate goal of instruction is learner acquisition of the terminal behaviors which define the task. Assessment tasks are identical to instructional tasks and assessment and instruction are continually interactive processes. This approach to assessment can be applied to any type of behavior and to behaviors of varying degrees of complexity.

The fourth approach to assessment emphasizes the evaluation and selection of appropriate instructional procedures rather than the assessment of learner characteristics. Called <u>trial remediation</u> (or Remedial diagnosis, Beery, 1968) this method of assessment involves establishing a criterion for individual performance, initiating an instructional procedure and retaining that procedure only if the performance criterion is attained. If individual performance fails to reach the desired standard, then another instructional method is utilized. The manipulation of instructional conditions continues until a set of instructional procedures is isolated which influences learned performance in the desired direction. Responsibility for learner performance rests entirely with instruction and the evaluation is, consequently, of the capacity of a given instructional procedure to exert a positive effect on learner behavior.

This assessment approach contains ambiguities in technique which must be solved by those individuals who function in the capacity of assessors.

Specifically, procedures must be developed for establishing performance criteria and for recording learner responses. Additionally, individual decisions must be made regarding the selection of initial instructional decisions. The strength of this method of assessment rests with the emphasis on learner performance and with the allocation of responsibility for learning to instruction rather than to the recipient of instruction. Despite the ambiguities inherent in this assessment approach, its potential is obvious, particularly with severely retarded children.

Although there are areas of overlap in the four assessment approaches detailed here, each approach has a distinct emphasis. The diagnostic-remedial approach emphasizes a detailed study of the psychological characteristics of the learner and the formulation of diagnostic hypotheses regarding the inter-relationships between psychological processes and learning and performance. Operant assessment stresses a study of overt behavior in relation to environmental contingencies while task-analytic assessment seeks to study patterns of performance related to the behaviors required by selected learning tasks. Trial remediation evaluates the effect of instructional procedures on learner performance. The significant feature of all four forms of assessment is the common emphasis on an efficient interaction between assessment and treatment. Effective educational programing for the mentally retarded depends upon such an interaction.

Organizational Features of an Assessment-Based Educational Program

Educational assessment, resulting in definitive and descriptive information about the learning characteristics and response patterns of individual children, has been rationalized as the basis for educational decision-making.and instructional practice. Consider the consequences of this orientation to the

to the organization of an educational program for the mentally retarded.

Placement and grouping practices should be radically altered by the defined assessment orientation. Traditionally, children are placed in classes and grouped for instruction on the basis of general factors which may or may not be relevant to educational practice. Factors such as chronological age, general achievement levels as measured by standardized tests, intelligence quotients or the etiology of the disability (organic versus familial) do not produce homogeneous grouping patterns nor do such grouping practices provide specific instructional direction for the teacher. If, however, children can be grouped on the basis of common learning characteristics (superiority of visual learning channels over auditory learning channels, for example), or on the basis of similar response to reinforcement, or on the basis of common skill patterns relative to the components of educational tasks, or on the basis of effective response to an instructional method, then group homogeneity on dimensions relevant to instruction is established. Systematic educational assessment permits and determines a relevant basis for educational placement and instructional grouping. Flexibility is an essential feature of this placement pattern. Children may require placement in more than one type of group during any particular period of time and, most certainly, may need to be moved from one group to another as changes in individual performance require accomodation through alteration in placement. Finally, teacher competencies and roles can be differentially defined and a match can ultimately be effected between children's needs and teachers' competencies.

Obviously, specialized diagnostic talents are required for the implementation of an assessment-based educational program. This raises two important organizational questions; the question of personnel and the question of the diagnostic

setting. Persons with specialized knowledge of educational assessment procedures must be added to the educational staff, preferably at a ratio of one such person for every seventy-five students enrolled in the educational program. The function and responsibilities of these persons would involve initially the design and organization of the assessment approach to be utilized in the particular educational setting. These educational diagnosticians would conduct the major portion of educational assessment for individual students. They would, however, be responsible for defining those components of assessment which could be conducted by other staff personnel, for training personnel in assessment techniques and for supervision of assessment procedures not accomplished directly by themselves. Further, they would be responsible for collecting individual assessment data and translating that data into educational prescriptions. The educational diagnosticians would have singular responsibility for interpreting assessment data to classroom teachers and for directing placement and grouping decisions. Finally, these diagnosticians would be the contact and liason persons between the education department and other departments in the institution relative to individual conferences and placement and programing decisions.

The role of an educational diagnostician is a relatively new specialization in special education. Consequently, qualified personnel are difficult to locate and to hire. It would appear appropriate and feasible for educational directors in institutions to select qualified teachers from their existing staffs and to send these people to universities for advanced training. Currently, the most relevant training is that which prepares persons as Learning Disabilities Specialists.

Coincident with the addition of educational diagnosticians to the instructional staff, serious consideration should be given to the organization of diagnostic

classes at the same ratio of classes to students as that applied to hiring educational diagnosticians. These classes would have multiple functions. Primarily the classes would function as intake classes where children could be placed, upon admission to the institution, for the length of time necessary to conduct a thorough educational assessment, to develop an educational prescription and to make placement and grouping decisions. The educational diagnostician would direct the activities of this class which could contain from one to ten children depending upon immediate circumstances.

These classes could contain, for longer periods of time, those children whose disabilities are so severe and complex that they require extended as assessment prior to formulating educational programs. It is conceivable that some children could remain in a diagnostic class for as long as six months for varying periods of time each day. The diagnostic class would also be a referral source for students who have been placed in classes but whose progress has been negligible and who require re-evaluation. Students would also be placed in the diagnostic classes for brief periods of re-evaluation when new placement considerations (extra-institutional or other institutional programs) are required.

It must be recognized that these diagnostic classes would have a specific but unique function which must never be confused with the function of other classes in an educational program. Diagnostic classes permit intensive study of individual behavior on dimensions relevant to educational planning. Consequently the patterns of grouping and the time allocations within these classes are substantially different than in other classrooms. For example children may only be scheduled for two hour placements in the diagnostic class during the intake period. If these classes function properly, in keeping with their purpose, they can greatly increase the effectiveness and efficiency of the

educational program.

The employment of educational diagnosticians, the establishment of diagnostic classes, the selection of a different base for educational placement and instructional grouping, the commitment to flexible placement patterns and the orientation to matching specified learner meeds with specific teacher competencies are the fundamental organizational features of an assessment-based educational program. It is not improbable that one of the major outcomes of this type of educational orientation and organization would be a major shift in emphasis in educational programing for the mentally retarded. The shift would be represented in terms of a de-emphasis on the deficits and dysfunctions imposed by intellectual retardation and an emphasis on the positive, modifiable variables in a child's behavior and performance. It is even conceivable that special educators might cease to apply diagnostic labels to children and begin to label instructional systems and teachers skills instead (Reynolds, 1968).

Conclusion

Cognizance of the fact that institutions for the mentally retarded have unique problems which can act as impediments to the development of an assessment-based educational program is imperative if such programs are to be initiated. Problems related to the severity, multiplicity and diversity of the handicaps of institutionalized children make the implementation of assessment approaches difficult but simultaneously indicate the absolute necessity for such approaches if educational programs are going to have any meaning to the lives of these children. Problems related to the educational orientation and reltaed competencies of teaching personnel require immediate resolution through staff re-training and re-organization. Perhaps the most significant problem relates

to the ambiguous objectives for education in many institutions for the mentally retarded. Educational programs rarely have well-defined objectives which are instructional in nature and which are directed toward changing, altering, correcting or remediating behavioral and learning deficiencies. This should however, not be viewed as a true restriction to the development of assessment-based programs. This particular orientation to education has its own objective, the evaluation of individualized educational programing and, consequently, generates and defines educational objectives as part of its own process.

The challenge to educators in institutions for the mentally retarded is to respond immediately and effectively to current developments in psychology and special education and to re-instate the educational philosophy and modernized educational procedures of Itard and Seguin in educational programs for institutionalized mentally retarded children.

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VII

Administrative Implications for Education at Various Ability Levels

Dr. Robert Erdman

The rapidity of change is a phenomenon observable in many segments of our society. Its tentacles have reached into most of our social and political institutions and have resulted in the necessity for man to attempt to modify his own ways of behaving. In some cases, change has been eagerly sought while in others it has been resisted. The fact remains that we are observing some of the most dramatic changes in the history of man. Our challenge is not whether we want change but how are we to plan for the changes we experience.

This phenomenon of change has been observed in our programs for the mentally retarded. To some observers, this is a paradox because on the one hand we are still struggling to establish services while on the other hand we are finding the necessity to modify those services established. Perhaps this will always be the case in a field such as mental retardation because of the availability of new knowledge and resources.

Historically, the state residential school was one of the earliest means of providing for the retarded. The schools were initially established for training this population at the educable and trainable levels. The purposes of the schools were gradually expanded to include provisions for the severely and profoundly retarded. In many cases, this latter program was developed without a philosophy other than lifetime custodial care.

The establishment of a state residential school was perceived by much of the citizenry as the means of fulfilling their obligation for the

care and training of the retarded. In many cases, schools were initiated without regard to the quantity or quality of services offered. Unfortunately, these attitudes toward residential schools existed for most of the first half of the twentieth century.

Now, during the second half of this century, a renaisance in philosophy and program in our state residential schools appears to be emerging. This revival of interest has been brought about by factors such as the advent of community and state programs, a population shift to greater proportions of profoundly and severely retarded individuals with a multiplicity of handicaps, a growing awareness that severely and profoundly retarded children can profit from training, and an awakening of society's attitudes and responsibilities for all the retarded. Consequently, the residential school today finds itself being cast into a new role...a role which is viewed as part of a continuum of services for the retarded...a role which demands that the philosophical and program foundations of the residential school be re-examined.

Thus, professionals in the field of retardation are confronted with a search for answers to some very basic questions if new courses are to be set in programming in a residential setting. Questions such as:

1. What is/are the philosophy(ies) of the program? Who determines?
2. What program(s) have been conceptualized and implemented? Are they consistent with the philosophy(ies)?
3. What role(s) (individual, unit) have been created to "execute" the program? How are they defined?
4. How was the role established? Who did it?

5. What happens when roles are not clearly defined? Overly defined? Cannot be defined?
6. How can roles be coordinated to achieve a common purpose? Whose responsibility is this?
7. How can we plan for change so that we minimize philosophical, program, and/or role crisis?

ORGANIZATION OF PAPER

The changing nature of residential schools suggests that the role of education must be re-examined. Therefore, the particular focus of this paper is on the role of education in the residential setting.

The paper is divided into three major parts. The first part presents a brief overview of education in a residential setting. The second part describes a pilot project at the Utah State Training School designed to strengthen educational (training) programs and some of the administrative and program problems encountered. It concludes with some questions to be considered for similar future programming. The final section presents selected concepts from the theory of change which may provide some clues for educational leaders in bringing about desired changes.

SOME PROBLEMS OF EDUCATION IN A RESIDENTIAL SETTING

The particular focus of this paper is on the role of education in the residential setting. Traditionally, the education departments of residential schools have been characterized by a high degree of autonomy. The children lived in cottages and were sent to school for varying periods of time ranging from an hour to a full day. What transpired in the school setting was not generally communicated to ward attendants, recreation

workers, or others entering into the life of the child and vice versa. Thus the child may have been exposed to a variety of programming without having the benefit of a team working jointly toward common goals which would enhance his or her development. In all probability, one area of activity may have at times negated the endeavors of another.

The school program was most frequently perceived as a place for the teaching of the 3R's. Some of the more progressive education programs were stressing cognitive skills, self-help skills, motor development, language development, and vocational skills. Today, the situation is beginning to change. What was once thought of as appropriate educational experiences for a given group of children no longer seems to suffice. This is partially being brought about by the shifting nature of the types of children served in the residential setting.

Further, residential schools are now beginning to perceive of their total function as one of education and/or training as contrasted to custodial care. Thus, what once was perceived of as the primary responsibility of an education department is now a total school responsibility. Profoundly and severely retarded children once thought of as not being eligible for school programs are now attending various educational activities. Consequently, a strong need appears for recasting the role of education and education departments into new frames of reference.

To further the challenge, professional observers find that in many states the increased number of community services appears to be duplicating the new efforts of the residential school. This duplication centers in the education and training function.

In summary, education departments in residential schools are confronted with the task of re-assessing the nature of their educational program, how this program relates to the total residential school goals and philosophy, and how the program relates to other community services.

A PILOT PROGRAM

General Program Description

The Hospital Improvement Program (HIP) at the Utah State Training School (USTS)* provides an example of how one state residential school is attempting to modify programs because of the changing characteristics of their population. The program is also illustrative of the challenge confronting residential schools in developing a philosophy of programming and coordinating staff efforts toward common program goals. In this context, education becomes an integral part of the total residential school program. The HIP has been in operation for approximately two years. Therefore, this description must be viewed as a progress report rather than as a report on a project which has been completed. Financial support for the project comes from Title I monies.

The basic goal of the project has been to explore a means by which more of the USTS residents could flow through a training program and be placed back into community programs. The general structure of the program is shown in Figure 1. One of the key concepts built into the program has been the family unit. Project participants were divided into a family of

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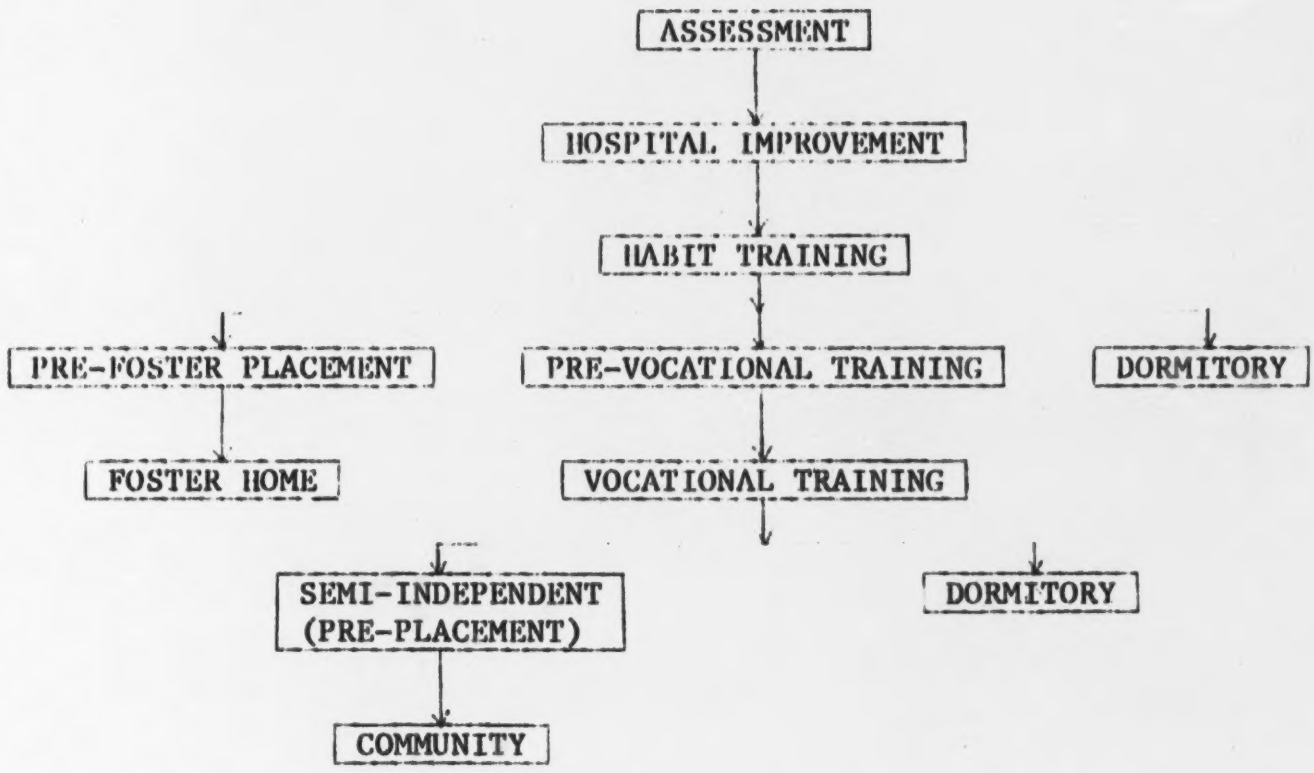
*The writer is indebted to Mr. Paul Sagers, Superintendent, and Mr. Gary Elton, Director of Professional Services, for their cooperation in supplying this information. Additional information about the project may be secured by writing to Mr. Elton.

FIGURE 1

STRUCTURE OF HIP PROGRAM - TITLE I
UTAH STATE TRAINING SCHOOL
AMERICAN FORK, UTAH



ten (five boys and five girls). Each family has two sets of parent-trainers (each set having a young man and woman for one-half day). The parent trainers attend school with their family and serve as teacher aides. The families live together and share common living quarters. They eat, have recreation, and attend school together. In other words, an attempt is made to simulate actual family living.

Movement of children from one project phase to another is decided at a weekly staff meeting. Behavioral check lists and logs are kept by the staff on each child to help record individual progress. The weekly

The project was initiated with 48 residents with CA's between 8 and 13. The average IQ was 17, and most of the participants had MA's between 1-2 years. Only four of the children could feed themselves when the program was started. The children were selected for the program because they were manageable and the staff felt they could profit from such an approach. Behavior modification approaches have been used extensively throughout the entire project. Consultants work with personnel in developing techniques to employ this method.

The following sections provide a brief description of the various program components shown in Figure 1.

Assessment Period

The major purpose of this period is to begin formulating behavioral prescriptions for each project participant. Psychological tests, behavior check lists, social maturity scales, and speech and hearing tests provide much of the data. Particular attention is given to preparing prescriptions for all phases of the participants' activities.

Hospital Improvement Period

The children officially start the program at this point. They attend school for one-half day (four hours) and spend the balance of the day in family activities. The school program emphasizes language development, music, physical education, and crafts. Each of these is taught by a specialist in that area.

Family activities stress self-help skills, locomotion, and socialization. These are under the aegis of the parent trainers with counsel from the professional staff, e.g., physical therapists.

Habit Training Period

This period emphasizes a continuation of the HIP activities. Children are given an opportunity to further develop the skills acquired during the first period.

At the termination of this period, children are programmed into one of three areas: pre-foster placement, pre-vocational training, or dormitory living. The decision again is made by the staff based upon the child's ability to profit from such an experience.

The reader should be reminded that since the program is relatively new, children have not of this date been programmed into the balance of periods indicated in Figure 1. The remainder of this description represents projected plans and descriptions.

Pre-Foster Placement Period

This period will be devoted to preparing a child for placement in a foster home. The staff anticipates that success of this phase will be highly dependent upon the availability of foster homes.

Pre-Vocational Training Period

This period will be used to help prepare children for some type of job role in the community or in the residential school. The plan is to work on the attitudes and work skills which will contribute to job success within some type of restricted environment. Boys and girls will be separated during this period.

Dormitory Living Period

The staff anticipates that some children will not make sufficient progress to warrant placement in either of the other two tracts.

Presumably, this tract will attempt to help make their living in the residential school as meaningful as an individual's ability permits.

Some Administrative Observations about the Project by the Residential School Administration

1. The project concept received varying degrees of resistance from groups in the residential school. The motivation for such resistance may have emanated from factors such as: potential change of the image of various professional roles, fear of loss of authority in the power structure, lack of knowledge about the new program, or lack of interest in making any change and maintaining the status quo.
2. Established professional and paraprofessional employees experienced trouble in changing their expectation level for the type of children served. In general, years of traditional practice have probably led employees to believe the children were less capable and therefore had limited potential for much favorable response. The administration felt that the newer employees responded much more favorably to the project because they had not established strong attitudes about performance level of various types of retarded children.
3. Some of the teachers resented having aids and/or parent-trainers in the classroom while teaching. Expressions from the teachers suggested that the presence of paraprofessionals represented subtle pressures that impeded their performance.
4. Some of the teachers had difficulty accepting the children as families for teaching purposes. They felt the more traditional methods of grouping children in special education programs were more advantageous.

5. The residential school administration indicated that it took more than one-half year to have the parent-trainers begin to think of themselves as families. Perhaps, the long traditions of the residential school had been so entrenched in the thinking of prospective employees and the regular employees that they found it difficult to change their behavior.
6. Many of the teachers had a strong orientation to teaching retarded children capable of profiting from the more formal special education curriculum. They expressed concern about teaching self-help skills, language development skills, etc., because of their lack of preparation to teach in these areas. Perhaps this is another manifestation of expectation as it relates to what is the purpose of an educational program in a residential setting. A plan of designed in-service meetings was developed to help better prepare the teachers for these roles.
7. The entire staff had to learn to function as a team and begin to think in terms of planning for the establishment and maintenance of common behaviors throughout a twenty-four hour period. For example, the staff discovered the need for maintaining a common vocabulary. They found that various personnel were using different words to describe bodily functions. Consequently, the children were not receiving consistent reinforcement for the language being taught in the school program.
8. The project to date has had a ratio of one employee to five children. Although highly desirable, this type of ratio could not be maintained without outside funding.

9. The project needed a well defined administrative structure. Superimposing a project cutting across traditional residential hierarchial roles created confusion as to role expectation and authority. The project belonged to no one area or group. In this particular case, the problem was resolved temporarily by having the Assistant Superintendent assume administrative responsibility for the project.
10. The parent-trainers were students from a local university. Although they contributed substantially to the project, their tenure with the residential school was relatively brief. Thus, the turnover of employees has created problems in maintaining project stability.

Some Areas for Further Study

The author recognizes that this particular project was one segment of a total residential school program. Presumably, this project and the many others currently being conducted in residential schools throughout the country are pilot attempts to modify programs in accordance with shifting school roles and populations. Residential schools are to be commended for their efforts in seeking more effective and efficient means of programming. However, efforts such as these are raising a number of questions which demand further study by all individuals with a commitment to improving services for the retarded. In particular, the role of education (training) appears to emerge in a state of limbo because the traditional parameters seem to be disappearing.

Assuming that residential schools are moving more toward an educational orientation, topics such as the following may warrant further discussion and study if the residential school is to proceed in program building with some degree of order.

1. The definition of a residential school as primarily an educational agency appears to be most notable. However, what does this mean for other existing agencies in a state or community with similar objectives? How will all these educational programs be articulated to protect the interests of the child? Could residential programs be more effectively and efficiently maintained in a variety of smaller community centers? What type(s) of models for residential school roles should be evolved?
2. The administrative structure of many residential schools is based on a prototype of hospital administration. In view of the apparent shift toward the educational orientation, do current administrative patterns best serve this need? Are there differences in administrative structure based upon program demands, or is a given structure suitable to a wide variety of programs?
3. Traditionally, responsibility for the educational component in a residential school has been assigned to the education department. What does a shift in attitude and program in the total school mean for this unit? Are there previously existing patterns which are becoming obsolete? What is the role of an education department under this new orientation? Is there still a role for the "professional educator" or is this role subsumed under other professional roles, e.g., social worker, psychologist, etc.?
4. Adoption of educational goals for a total residential school is a relatively complex task. Who determines the nature of these goals and the methods by which they are achieved? Are these

really any different from those implied by or explicitly stated in most traditional programs? Should they be?

5. Teacher education programs preparing teachers of the mentally retarded have represented a potpouri of approaches. Only within the past decade have we really begun to observe varying degrees of differentiation between programs preparing teachers of the educable and trainable. Do current trends suggest that even greater differentiation is required? Do we have to begin preparing specialists in given curricular areas as contrasted to generic teachers? Do we need "certified teachers" for the so-called new educational roles emerging in residential schools?
6. The changing of attitudes and behaviors in residential school staffs appear to be a critical dimension for success of the new program orientation. What method(s) do we have which can assist in this task?

THE PROCESS OF CHANGE

The changing role of our residential schools is a reality. These changes are taking place whether they are desired or not. The challenge to educational leaders and/or residential school administrators becomes one of planning for this change and attempting to understand some of the dynamics associated with this process.

The process of change is a complex system. Social psychologists and others are just beginning to formulate theories which might explain the dynamics of this phenomenon. At best, we have some clues which can serve as tentative guides for the present. Future research should lend even greater clarity and precision as to the mechanics of the process.

Basically, the concern of this discussion focuses on seeking ways to change behavior in the staff of an educational program--changes which are necessitated because of new knowledge resulting from empirical or research findings.

Successful programs do not exist in a vacuum. They exist because of people--individuals with competence, motivation, a willingness to work toward common goals, and an attitude of inquiry. Residential schools demonstrating this progressive, forward-looking approach have usually been able to assemble a group of individuals with these qualities. They recognize that change is constant and that plans must be made for this to become an integral part of program planning and implementation.

What then are some clues that can serve as a guide in the process? The following discussion is a brief resume of some of the ideas proposed in Theory into Practice: Changing the School (1).*

All of us have found ourselves in the roles of being acceptors and rejectors of change, depending upon our frame of mind and the point at issue. We may have also found ourselves shifting from one role to another. Theoretically, both roles are essential ingredients in the process of change. The rejector may help in leading to refinements of an idea which may in turn increase quality and sophistication. At the same time, rejection may lead to a state of inertia and no changes take place. Likewise, blind acceptance is as harmful as prolonged and unreasonable rejection. The task of educational leaders is to understand the processes involved in each of these roles so that we may plan accordingly.

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*The reader is directed to this reference for a more comprehensive discussion of the topic.

Research findings in the field of agriculture and rural sociology (1, p. 265) suggested that the process of accepting an innovation consists of the following five stages:

awareness ⟶ interest ⟶ evaluation ⟶ trial ⟶ adoption

Eichholz (1, p. 265) has proposed that a theory of rejection of an innovation consists of five parallel stages. These are:

awareness ⇢ disinterest ⇢ denial ⟶ trial ⟶ rejection

He developed his theory as a result of using depth interviews with forty-five elementary teachers concerning their attitudes toward audio-visual media, including materials ranging from films to globes. Each teacher had been previously identified as a rejector.

These teachers rejected an innovation in five different forms--ignorance, suspended judgment, situational, personal, and experimental. All of these forms are on a continuum, and a teacher may move from one to another. Such factors as the number of years of teaching experience or the grades taught made no appreciable difference in whether a teacher rejected a specific innovation.

Based upon this research, Eichholz (1, p. 266) proposed the following framework for the identification of the forms of rejection:

insert table 1 here

He suggested (1, p. 267-268) the following steps that can be taken to overcome the various forms of rejection:

> "Ignorance. There is little reason for any teacher to live uninformed in a culture so permeated by mass communication. However, information can be made more readily available by placing professional magazines in the lounges; by regularly discussion at faculty meetings innovations and changes occurring in other schools; and by creating both informal and formal channels of communication--finding out more

TABLE 1

A Framework for the Identification of Forms of Rejection

Form of Rejection	Cause of Rejection	State of Subject	Anticipated Response
Ignorance	Lack of dissemination	Uninformed	"The information is not easily available."
Suspended	Data not logically compelling	Doubtful	"I want to wait and see how good it is before I try."
Situational	Data not materially compelling	1. Comparing	"Other things are equally as good."
		2. Defensive	"The school regulations will not permit it."
		3. Deprived	"It costs too much to use in time and/or money."
Personal	Data not psychologically compelling	1. Anxious	"I don't know if I can operate equipment."
		2. Guilty	"I know I should use them, but I don't have time."
		3. Alienated	"These gadgets will never replace a teacher."
Experimental	Present or past trials	Convinced	"I tried them once and they aren't any good."

about the personal relationships among teachers and using these as well as formal routing channels to circulate information.

"Suspended Judgment. Some teachers want to wait and see how good a new idea is before they try it. They view with anxiety any change that might endanger past success. However, a few teachers in any school will accept change readily and the administrator should encourage them to experiment instead of attempting to involve the entire faculty. Gradually the successes of a few will 'spin-out' old practices. The principal, therefore, should constantly communicate accomplishments to the entire faculty and encourage their support.

"Situational. An environment conducive to experimentation is effective in meeting rejections for situational reasons. Change is best implemented as a group endeavor, where an individual teacher's fear of a personal failure is alleviated. Up-to-date materials should be available, especially for the newer media. Equipment should be kept in good condition and used through a functional check-in and -out system. Heavy equipment should be mounted on carts; screens and black-out drapes should be a permanent part of every classroom.

"Personal. The teacher who feels anxious or alienated about change witnesses the acceptance of change by others and builds a defense to rationalize his guilty feelings. Proofs, examples, or appeals to logic will not overcome this resistance. Efforts to force change will lead to greater rebelling. A sound approach is to make haste slowly. Adopting a sympathetic attitude, the administrator should encourage the teacher to continue past practices regardless of what his colleagues are doing. However, he should indicate that some small change might prove helpful and offer his assistance. As faculty acceptance of change persists, pressure mounts against the rejector and eventually leads to a trial stage and some experimentation.

"Experimental. Mere trial or experimentation does not assure acceptance--in many instances, it provides the means to reinforce attitudes of rejection. While the rejector may be experimenting only to support his rejection, a sympathetic administrator, offering encouragement for the attempt, might turn even this into acceptance."

Bringing about major change requires careful planning and the development of appropriate strategies--for without these we may have chaos. Programs in our residential schools are already feeling the impact of change. In some cases this force is helping to create stronger programs, and in other cases it is contributing to mass confusion. We

can no longer take a "wait and see" attitude but must plan for these changes in a most aggressive and creative manner, utilizing the best of knowledge available at this time.

REFERENCE

Theory into Practice: Changing the School, Jack Culbertson (ed.), College of Education, Ohio State University, Vol. II, No. 5, December, 1963.

VIII

Resources for Implementing tha Administrative Model

Dr. Phillip Roos

I was assigned the topic of Resources for Implementing the Administrative Model. As I tried to prepare this paper I became somewhat confused because I didn't know what the administrative model was. As I looked at your program I noticed some previous speakers had discussed this model, but since I wasn't here, I was working somewhat in the dark. However, I'll proceed as best I can. And if I'm talking about a model different from the one that was discussed with you, chalk it up to ignorance on my part. When I saw the people you had discussing this subject, I assumed that there would be several models emerging. I could hardly see these gentlemen agreeing on anything.

Have any of you been in Grand Central Station lately? My office is located over Grand Central Station. Have you seen this computer that sits down there? If you're in Grand Central take the hall that leads to Lexington Avenue and you'll walk by something labelled Astrojet or Astrostar, something like this. It is a computer. Long lines of people usually wait to query this computer. The computer, of course, sits there in air-conditioned luxury while the consumers happily wait in line. It is glass enclosed so people can stand there and watch it at work. This computer, of course, is a computerized astrologer. I understand when you get up to the window after standing in line (if you survive long enough), you tell the fellow who stands there the time of day you were born and the day of the year. This information is punched on an IBM card, and fed to the computer, and presently you are handed a computer read-out. They're making money hand over fist with this gimmick - five bucks a shot. And you can see these cats walking off with their computer print out,

reading about their past, present and future.

I'm amazed by man's incredible capacity for fantasy. Just astounded. We project ourselves into the future and frequently these projections are totally unfettered by reality. When the process becomes extreme, we describe it as either psychosis or as long range planning, depending on the context in which it is done. So I thought I would begin by surveying with you the reality of today, with regard to residential services for the retarded, because I've sat in on some of these planning meetings. Really, I think it was generous on the part of the participants to think of it as long range planning, for it had little or no relationship to reality.

I think most of you are familiar with Mental Retardation 68, the President's Committee Report. It essentially presents an encapsuled summary of the state of affairs in residential centers today. It describes a rather sordid picture. One of overcrowding: the President's Committee estimates we would need 50,000 more beds to eliminate the overcrowding in state institutions. One of long waiting lists: they estimate 25,000 beds would be needed to absorb today's waiting lists. One of understaffing: they estimate that it would take 50% more staff to meet the minimum AAMD requirements. One of inadequate staffing: only 11% are professional people. Among the attendants, which comprise by far the largest group of employees, they indicate a 20% turnover within the first year. One of little progress in staffing: they indicate that between the years of 1963 and 1967 (which were our golden years) there was no significant increase in the ratio of staff to residents in our residential institutions. The picture is gloomy with regard to the physical plants as well. You will recall that 50% of the buildings are 44 years old or older.

Funding, in general, has been totally inadequate. A year-and-a-half ago I went to evaluate one of the institutions in one of our southern states, and

I found to my great horror that the per day cost per resident was $2.60. The attendant was still working 12 hour shifts - 60 hours a week for the salary of $160.00 a month. Now this was a year-and-a-half ago. And indeed in 1968, the average per diem cost in our United States state institutions was $7.60. As you know, we often compare ourselves with the countries in Europe (particularly Sweden and Denmark) where the per diem costs vary from a low of around $16.00 to a high of around $38.00. And yet we think of the U.S. as probably the most affluent country in the world today. Obviously, we have not focused our concerns on the area of mental retardation.

Now, let me take a brief look at the administrative models which we still are likely to find in our residential institutions today, for these are the models within which each of you have to operate. In the majority of institutions which I have seen, certainly in many of them, the basic model is that of a technocratic autocracy. You all know what a technocratic autocracy is, I'm sure. It's essentially a management monopoly based on the philosophy that only God can run heaven. Do any of you recognize this model? It is a system that is based on a pseudo-syllogism which runs something like this: Proposition #1: you define the area of mental retardation in terms of a specific discipline -- "Mental retardation is a psychological problem." Proposition #2: 'bnly psychologists can manage psychological problems, obviously." Proposition #3: "Therefore, 'only God can run heaven' -- i.e., only psychologists can manage mental retardation programs." And here you have the basis, the syllogism, the "logical" rationale for setting up a system in which all key administrative and management spots are filled by psychologists. You have a technocratic system in which a power structure is vested in a particular discipline. And you find in many states not only is this kind of system used to develop the power structure within the institution, but it is embodied in the laws of the state. The

superintendent of the institutions for the mentally retarded will be a Ph.D..psychologist. The Commissioner of the state will be a Ph.D. psychologist. Now you recognize full well that I'm using the psychology as an example; being a psychologist myself, you see, I feel people will be less defensive. You could equally well say "mental retardation is a medical problem," "Mental retardation is an educational problem," and you can use the exact same syllogism. The fallacy, of course, lies within the first two premises. Mental retardation is not exclusively any one type of problem. Likewise, it is fallacious to assume that because you belong to a particular discipline, you are the only one who can manage this type of problem. This is the fallacy of confusing functional authority with line authority. And yet, it is this kind of system which still permeates many of our institutions. It leads to an interesting phenomenon: the development of what I call pseudo-teams. You know today the sexy thing is teams, right? You've got teams for everything. The pseudo-team is a situation in which certain fortunates are admitted to the Pantheon, as what I call "para or ancillary deities." Have you ever heard the term "paramedical"? I immediately develop a constriction of the gastrosplenic ligament, which is a painful malady, let me assure you, when I hear this type of term. "Ancillary professions." And of course this whole system leads to professional lobbies, to power plays of various kinds, and what not.

A second characteristic of our administrative model today, is what I call departmental fragmentation. In most institutions that I have seen, even in recent years, staff are organized on the basis of a monolithic table of organization. You have "god" up on high, and then you have some of the "ruling clergy" in strategic spots just below, one of these is usually called a "clinical director", right? And under this happy chap you have a number of

departments. Department of education, social work, psychology, I don't know what else, foot doctors maybe, recreation, and so on. Each of these departments becomes a sub-empire with a department head. Now what happens is a fragmentation in terms of each of these departments. Each becomes a kingdom in and of itself. Unfortunately, down here in the distance somewhere is what I call the "victim," or the "consumer." That is, the unfortunate retardate who happens to live in this facility. Because of this fragmentation, frequently little or no effective programming reaches this victim. Now these departments, in order to maintain themselves, develop what I call "secret languages." That is, each of our professions has developed its own badge of individuality, a language which is almost totally noncommunicative with the other disciplines. This is one way in which you earn your degree, you learn the language. And then, of course, you cultivate it, so that in a staff meeting, for example, each member of a discipline can hold forth at great length, and no one else has a clue as to what he is talking about, and therefore, of necessity, has to agree with him. Well, I won't belabor the point. The unfortunate aspect is that both of these current management strategies have as a basic consequence a significant curtailment of effective services.

A third characteristic of the current situation is what I call the institution sub-culture. We frequently talk about changing the institution. The institution, unfortunately, is composed of a number of sub-cultures; it's not a homogeneous social organism, and this entails serious problems of communication. I really don't want to take a great deal of time with this, since I hope we'll have time for discussion. Very briefly, I see at least three sub-cultures in addition to the basic substratum, namely the consumer sub-culture, which is usually silent. But there are at least three staff sub-cultures, right? The

B.W.'s, the I.T.'s and the W's -- The Big Wheels, the Ivory Towers, and the Workers. Now each of these has its own subculture, its own frame of reference, its own mores. The Big Wheels are the superintendents, and the lesser deities such as the business manager, the clinical director, and the director of personnel. They are the front office boys. They are the ones who present the facade of the institution to the outside community. They peer into the great distant future and plan and plan... They enunciate the basic philosophy and goals of the institution. In general this is a transient population. The average life span of an institution superintendent in this country is two years. So these people come and go with rapidity and as such they are perceived by the rest of the institution as a temporary nuisance. Fortunately, they are confined to the front offices, the large desks, and the air conditioned rooms. They have little or no contact with the worker group, and they can be readily "handled." The Ivory Tower personnel are, of course, the happy professionals. They are the neck-tie boys, the office boys, the ones with the specialized languages I was just describing to you. Most of them have their own thing. It is either the giving of Binet tests and Rorschachs or intensive individual psychotherapy with highly selected consumers, who are non-representative of the population, or what have you. The educator, too, often fits into this category. Now the Ivory Tower boys are interesting. Fortunately, they too spend most of their time away from the Workers. They're entertaining, because they usually have bizarre ideas, which entertain the Workers, but the Workers have to be careful, because these Ivory Towers can bother you if you let them. If you listen to their wierd ideas there's going to be more work, so you've got to take them with a grain of salt, right?

To the Big Wheels, the Ivory Towers are seen as a potential threat because

they can get you in deep water. If you give them a free rein, they're going to engage in all kinds of activities that are going to reflect adversely on the Big Wheels, particularly if the Big Wheel suffers from what I call the "don't make waves syndrome." That is, if the superintendent believes that the "good" institution is the quiet institution, where every thing is stable.

Now we come to the workers. The workers, of course, are the cats who do the work. They are the attendents and the food service workers and the janitors, and all these people. There are a few people who hang in the middle between the Ivory Tower and the Workers and become schizophrenics. I'm thinking of the nurses, for example. They try to circulate in both of these cultures, and they are almost uniformly very unhappy and mixed up people. Now the workers, mind you, have been there a long time, and have a stable culture. Their basic criterion is getting the job done as quickly and simply as possible, with a minimum amount of energy. They have rather rigid and traditional rules; they have a strong in-group feeling. What happens when the superintendents invade the world of the worker? The main line of defense is what I call the N & S syndrome (the "nod and smile syndrome"). You've seen this defense if you've ever made rounds or gone on a walk on the wards with a Big Wheel. The Superintendent walks in and looks about knowingly, not having a clue what's going on, and he says "Hey, you're tying these kids in the beds; I don't want to see anymore kids tied in beds." He may elaborate with "It is inhuman, it's dehumanizing, I want you to take the kids out of these restraints." And the attendant says, "Yes sir doctor, that's a great idea, I'm glad you thought of that, thank you sir, they'll be taken out," etc. That's the nod and smile syndrome. As soon as the superintendent leaves,

the attendants hold their sides and exclaim, "Did you dig that cat, untie the kids! Man, this guy's out of his mind. They'll be climbing the walls, they'll be choking us, they'll be fornicating on the floor," and all these kinds of things. Knowing full well that he isn't going to come by again for a year, not a kid gets untied. Well, I could go on like this, but I'm describing a major problem, really. Let me give you a complete example. The superintendent says "We're going to habilitate the mildly retarded." Have you heard this? "They could potentially be constructive members of society and we're going to get them out into the world." Habilitation programs are developed. Meanwhile, back on the ward, the word trickles down to the chief attendant that there will be a program to habilitate the mildly retarded. He calls in his attendants and says "Hey gang, the guy's finally split his skull, he's going to get rid of all our good working residents. If he gets rid of these working residents, where are we going to be? I mean, we're going to have to do all this work ourselves. So, I'll tell you what, when the cat comes around, you hide all the good working residents, and you spread the word to them that they're not to talk, I mean, like to play dumb." That's what happens. And presently, there are no habilitative subjects in the institution. I caught on to this strategy when I was superintending in Texas. I went to my attendant group and I said, "Gang, fear not. Yes, we are going to habilitate our good working residents, but we are going to replace them with additional paid staff, because I sold this bill of goods to the legislature." Do you think the workers cooperated? No, ladies and gentlemen, they did not. They knew that it's very easy for the chief attendant to say "Joe, (Joe being a working resident) go over there and pick up that pile of fecal material." But he can't say that to another paid employee. In short, replacement

of the working residents by paid employees introduces all kinds of morale problems. We don't have slave labor any more.

Before too much depression sets in, I shall move on to happier subjects, namely the development of strategies for maximizing existing resources. First, let us analyze development of a favorable management style. Let me mention, without getting technical, the management theory of Blake and Mouton. A manager can be primarily concerned with work output, with relatively little concern for the people who do the work. The extreme of this orientation is what we might call the task master manager, the guy with the whip who says, "Man, get the lousy work done. I don't care if you feel happy, sad, or indifferent." In the other extreme, the individual can be primarily concerned for the worker. "I want good morale, I want everybody to be happy, everybody pulling together." Plenty of vacation time, sick leave, and all that jazz, with little concern for work. We'll call this the "country club" manager. There's an intermediate position. The middle of the road manager, who vascillates from concern for people to concern for work. For a while he says, "Hang loose gang, we're all in this together, take it easy, don't work too much; if you don't feel well, go home; bring your wife to work with you," etc. But when he suddenly sees the work output going down, he panicks and he says, "All right, now we've fooled around long enough. Everybody to work. We're going to can you if you don't get to work on time." This is the middle of the road manager who vascillates from one extreme to the other. Now, according to team management theory, the manager adopts the basic philosophy that concern for people and concern for work are not opposite poles of a continuum, but they go together. The team manager is concerned for people and for work, assuming that people basically <u>want</u> to work. Now that may be a somewhat shaky

but modern management theory makes this assumption and concludes, therefore, that for management to be effective, the worker must be involved as a team member in getting the work done. He must be involved in decision making and policy formulation. By making work meaningful, by involving the worker, the work gets done and at the same time the worker is happy because he gets gratification out of doing a good job. So much for management style.

Second, the matter of cummunication. To maximize the use of existing resources, there must be a sharing of information. Essentially we're dealing with two dimensions with regard to communication: exposure and feedback. Exposure is a situation in which a superior gives information to the subordinates. "Gang, next year we're going to build a new building, and in the building we're going to put everybody that's bedridden, blah, blah, blah." Feedback is the situation in which the subordinate feeds information to the superior. In an effective use of resources, there is ample opportunity for both processes. That is, superiors freely share information with their subordinates, and give the subordinates ample opportunity for feedback (that is, to give information to the superior). In most of our institutions, there is ample exposure -- that is the Big Wheels give out the word freely enough (memos, and all this), but there is very little opportunity for feedback. That is, there tends to be a unilateral flow of communication.

The third characteristic of an effective strategy for maximizing resources is a decision making process in which there tends to be a sharing of power. And, again, this gets back to team management. It is possible for you to diagnose a team so as to differentiate a team in which there is a sharing of power, in which there is team management, from a pseudo-team. First, you can assess the seating arrangement. Compare the seating arrangement where "god"

sits at the head of the table with the deities around him. (Pseudo-team.) with the seating arrangement where everybody is sitting around the table and you can't identify "god", unless he's wearing a cloak of the priesthood (a white coat or stethoscope, or something like this). Such symbols allow you to conclude "Ah, yes, there is 'god'; I can see him right away." In that case you've still got pseudo-team. Next observe your communications. Assume the communication runs something like this, "Mr. Jones, what do you think a about the patient?" and Mr. Jones says "Blah, blah, blah, blah." "Thank you, Mr. Jones. Mr. White, what do you think?" In this case, you've got a pseudo-team. If the communication consists of general participation and there is interaction among the participants, you're likely to have a genuine team. Furthermore, in team management, once discussion has ceased, you do not hear one guy saying "Having heard all this, I have now reached the conclusion that this is basically an autistic child, and what we need to do is blah, blah, blah..." If you hear this, then you're still dealing essentially with a pseudo-team. If instead you hear this: "It seems that we've discussed this at length, perhaps it's time to consolidate our information." And then one guy says, "I think it's an autistic child." Another guy says "I'm not so sure about autism, maybe it's something else." And nobody says, "O.K., having listened to this now, I, as "god" will decide." Then you've got a real team, one in which power is shared.

A word about in-service training. Have you all heard of in-service training programs? You've all heard of this cheerful IST program (in-service training program) of the federal government -- $25,000 a year? Everybody got that kick, right? Beautiful program, tremendous goals -- "We're going to change these cats down here (i.e. attendants) and make them real go-getters." Problems have become evident. We're beginning to get research results on this program,

and you know what we're finding out? Without boring you with the gruesome details, we're finding out that the victims of the in-service training programs are revealing increased information about mental retardation, but no attitude change. And that's what it's all about -- that's the name of the game, changing the attitude toward the retarded. Obviously, then, the models we have been using in in-service training have not been effective models. And if you look at most in-service training programs, you will find the very same type of sordid situation you can see in this room. Namely, one jackass braying happily at a bunch of receptive vegetables. It's the didactic model, and although this model may be somewhat appropriate for a highly intellectual and sophisticated audience such as yourselves (and it is even doubtful that it is effective with you cats) it seems most ineffective for the unsophisticated worker in the institution. In addition, there is the interesting phenomenon that in-service training takes place in an in-service classroom. Do any of you have in-service training classtooms in your institutions? The attendant spends an hour in class and then goes back to the ward, which is where the education takes place. The old-time attendant says, "Man, you've been up there in in-service. Kind of amusing up there, isn't it? Now, I'm going to tell you how it's really done." And don't think that isn't what goes on. So these cats are completely indoctrinated by the "old guard." And the administrator asks them "How's things going?" and they reply "Things ain't going so good. They're telling us on the wards that there's nothing happening up here. And you've been telling us that we should do thus-and-such, but they're telling us that ain't the way it's being done." It's amazing what you learn if you keep your mouth shut.

We are beginning to think, then, that if we are going to maximize our

existing resources, we have to develop other strategies for in-service training. One possibility is the development of orientation wards, where all new employees are assigned to a training building -- perhaps for a month, perhaps for six months. In such a setting we have control of the total environment -- of the sub-culture -- within which that individual operates. Highly selective trainers would supervise new attendants eight hours a day, not in a classroom, but on an actual living unit, with residents, where the culture is manipulated. Other strategies would include role playing, sensitivity training and the use of the apprenticeship system (where a new attendant is assigned to an attendant of known value). Another possibility is use of closed circuit television to bring in-service training directly to the living unit. A form of infiltration, you know, since everybody is addicted to television, and hence one could brainwash the attendant this way. In short, in-service training can be a valuable asset in maximizing existing resources but it must be modified from the traditional model.

Unitization is the current strategy to break through this departmental fragmentation. The institution is reorganized along unit rather than along departmental lines. Each of the units is staffed by one or more representatives of each of the various departments. Those professionals become administratively responsible to the unit leader, with the result that they have to surrender their specialized languages, and their dreams of building their own departmental empires. The unit team is now charged with the full care, treatment, training, and education of all residents assigned to the unit. And then the challenge is to evaluate the effectiveness of such a system in terms of results. Needless to say, development of such a system is fraught with hazards and all kinds of happy objections including resistance from the administration, resistance

from the professionals, resistance from the workers. The chief psychologist might say, for instance, "Hey man, we can't do that. Psychologists should be responsible to a psychologist; only a psychologist can supervise psychologists; only a psychologist can hire a psychologist." What he's really saying is "Man, I don't want to lose my empire. Without a department, I'm going to be an emperor without an empire." The same concerns could apply to the social workers, the physicians, and even the educators. I could go on at length about the problems of unitization, but it is a coming strategy, and I think one that has a great deal of potential merit in terms of delivery of better service to the consumer. A final strategy for maximizing resources is the development of career ladders. You're all familiar with the career ladder concept? The idea is to evolve a system whereby a lowly worker, through additional experience, training and education, can progress upward in the hierarchy, eventually reaching Big Wheel status. It might appear that everybody would be in favor of this and say "Hey, this gives our people an opportunity to move upward, incentive, greater expertise, additional education paid for by the state, and so on." Yet if you think such career ladders are met with enthusiasm, not so, my friends; no change is met with enthusiasm. I have noted at least two sources of opposition: one of them is the unions, the other is the professionals. The unions say, "wait awhile, you're talking about additional education. Our people don't want any additional education, they don't want to go to school; man, that bugs them. They want to get promoted on the basis of having lived long enough." And I won't belabor this point. The professionals say, "Wait awhile, you're going to sneak in through the back door; that won't do." Nurses, for example, might say, "What do you mean, an attendant's going to be a nurse, technician, and then an l.p., and eventually

an R.N. -- no, no, if anybody's going to be a nurse they're going to go the same hard route that I went, they're going to go to school for half a dozen years, and then get an R.N." Except for these kinds of opposition, the career ladders are going over swimmingly well.

Now, how can we better tap neglected resources -- and remember, I'm talking about resources for implementing the administrative model (I need to remind myself occasionally that that's the subject). To tap neglected resources, including other community resources, we must first eliminate false dichotomies. Hence, people still speak of the institution and community resources, rather than of the institution and other community resources. The institution is part of the network of community resources, and we must get rid of the me-you dichotomy, the "us institutional cats" and the "they community cats" if we are to make maximum use of other community resources.

The use of consultants can be a bad scene. Many institutions could get a great deal of mileage out of consultants, but frequently the consultants are improperly used. It's necessary to prepare the consultant and to prepare the staff. It is inadvisable to throw the consultant to the staff with the admonition, "Here's your consulting psychologist, good luck." Instead, you sit down with the consultant and you explain, "These are our problems, and these are the ways you can help us with our problems," and you prepare the staff members by stating, "We're bringing in a consultant, now here's the way we can use this cat." If you're a team manager, you say, "Gang, we have an opportunity to bring in a consultant. How do you think we can use this cat?" And presently, through operant conditioning techniques, you get the members of the team to outline strategies for using the consultant, and you say, "My, that's a splendid idea, and they've covered every point you had

planned to make. That's what's known as psychopathic manipulation, or operant conditioning, depending on your school of thought. Well, a consultant, as I see it, should be a source of information, an independent observer, a resource to the staff, but not a practicing clinician, and not a decision maker, or a referee, then he has lost his effectiveness; he immediately becomes the enemy of a great meny people in the institution. Well, I won't belabor the use of consultants -- but they can be a very important resource.

Another resource is to affiliate with universities, with community colleges, with junior colleges, with medical schools, and so on. This strategy is becoming more common. The use of joint appointments for staff has proven to be extremely useful.. Placement of students in the institution can also be valuable, but it's important that the students are placed in meaningful situations, that they are integrated with the functioning of the institution, and that they are placed in it early enough. Placement of graduate students is frequently too late; we should be involving students during the undergraduate years, perhaps during the later high school years. The SWEAT program, which I think some of you may be familiar with, was an excellent strategy for involving young people in meaningful interactions in institutions, early during their career development, at a time when they still have freedom to make career choices.

Finally, let me comment on two neglected resources, the first of these is the use of generic community services. We often give lip service to use of generic community services, while we're building bowling alleys, skating rings, and theatres in the institution. Yet those same services may be found in a nearby neighborhood. It is probably much more effective to take the

residents within the community, and to let them use the community resources that exist therein. The second neglected resource is the use of volunteers. Oh, I could talk at length and really put you to sleep (an example of hypnotic induction, as it were) about uses and misuses of the volunteer. The traditional role of the volunteer has been that of the happy mother substitute, one who gives birthday parties, and lights Christmas candles, and who brings licorice candy to the wards. A lovely scene. There are, however, new challenging and emerging roles for the volunteer. He can become an extension of the professional staff, and serve as a member of the training and educational team. We found, in Austin State School, that we could use volunteers in numerous roles. They functioned as psychometricians, and were very adequate at administering Binets and Wechslers and Benders, and similar happy tests. Actually, they performed those tasks with somewhat fewer scoring errors than the staff psychologists, and they were immensely more interested in doing this. They were supervised by a psychologist who helped them get more meat out of the thing, and who might have interpreted the results. Meanwhile, the psychologist was doing something he found more interesting. We used volunteers in speech therapy, we used them in operant conditioning programs, we used them in monitoring programmed instruction, and a myriad of other professional activities. In order for this type of program to succeed, the task must be meaningful, the volunteer must be trained and supervised, and he must be carefully selected. He must be systematically reinforced. You don't pay him, you see, and the reason we keep going to our jobs, my friends, is the secondary reinforcer in our culture -- dough, money. Try an experiment some time -- stop paying your teachers and see how quickly the behavior extinguishes. And there is very little spontaneous recovery, I assure you. But we don't pay

the volunteers, so you've got to develop a system other than money, such as recognition, appreciation, status, and all these kinds of happy scenes. It is vital, of course, to prepare and work with staff, because staff is likely to feel threatened. If you say to a psychologist, "Here's this cat with a high school education who is going to start giving Wechsler's" the psychologist may hit the ceiling. "I went to school twenty years -- twenty years, I was a little slow -- but twenty years it took me to learn to give a Wechsler!"

Let me now discuss parents as a valuable resource. We have mishandled parents in past years, I'm sorry to say. I shall give you examples of mishandling of parents by us professionals. We have attempted to cast the parent in the role of villain, as the one who is responsible for much of the tragedy that we find in the child. We have also approached him from the benign standpoint that "We are going to counsel you." Have you heard about parent counseling? (I wrote a lovely article on this subject some years ago). In counseling parents we frequently focus on two goals which I call "false" goals. The first of these is the goal of "acceptance." We try to help the parent accept the fact that he's got a retarded child. Ladies and gentlemen, you don't "accept" having a retarded child. There are some things in this world you simply don't accept, not now and not twenty years from now. So, if as a counselor, you set this as your goal, you're wasting you're time. Don't take my word for it -- Olshansky has written a lovely article on the false goal of acceptance. The second false goal consists of attempting to "lift the depression." As a professional works with a parent, he often begins to get the suspicion that this parent is depressed. Since in this world you aren't supposed to be

depressed, you're supposed to be smiling and happy and full of hedonic tones, the counselor reasons, "I'm going to help this cat work through his depressions. I am going to give him an opportunity to work through his ambivalences toward his child, to express his deathwishes and all this happy jazz, (right?) and then he won't be depressed any more." Unfortunately, the normal reaction of the parents of a retarded child is a state of chronic depression. And some people just manage to live with chronic depression. But we haven't seen that, you see, we don't tolerate depression.

Another error in dealing with parents is what I call the "veil of secrecy," or the "mystical confidentiality bit." We don't share with the parent I.Q. tests, achievement tests, pathological tests, medical findings, and so forth. We keep our folders close to our vests, and keep our pronouncements vague. "Ah, yes, the psychologist indicates that your child is functioning at a somewhat retarded level." Still another error in dealing with parents is what I call "professional omnipotence," consisting of making the decisions for the parent. In our wisdon we decide what is best for the child, and we then impart this wisdom to the parent. The parent, my friends, should make the decisions for his own child. We are not all that omnipotent. And parents no longer dig this scene of the wise oracle handing out the word. Finally, let me mention what I call the "ignoramus syndrome," or the "deaf ear syndrome," by which I mean the refusal to recognize the parent as a valid source of information, so that frequently we refuse to listen to what the parent has to say. For example, the parent brings the child to the institution and says, "This child reacts very badly to Dilantin. Don't give this child Dilantin.

In the past the child climbed the walls. No Dilantin." "Yes, yes, we understand, thank you for telling us." The first thing we do is drop Dilantin into the kid. This is, I fear, not the exception, but the rule, we treat the parent as if he were an ignoramus.

Constructive interaction with parents stems from recognizing the parent as a decision maker, and as a member of the multidisciplinary team. There should be sharing of information and a genuine partnership between professionals and parents. The parent is a valuable resource. In some institutions parents have established, and I'm sure you're familiar with this (parent P.T.A.'s), each living unit has its own group of parents, who meet regularly, have their own officers, meet with the staff, and plan programs for that living unit. Recently, I had a delightful experience while visiting one of these P.T.A.'s. After the meeting of the group, the president of the P.T.A. got me aside and said, "Hey, man, we're doing something rather interesting here. I'm in aeronautical engineering, and I am building a little device to deliver electric shock to some of the kids in this unit by superheterodyne radio." Mind you, I discussed this approach maybe seven or eight years ago with administrators, who threw up their hands and said,"We couldn't do this in our institutions, the parents would lynch us." Only last year, we had a symposium at Suffolk State School: Norm Ellis, Jerry Bensberg, Cecil Colwell, Luke Watson, and I were on a panel there discussing operant conditioning, and one of us discussed the use of adversive conditioning. There were several expressions of concern that parents would object strenuously. Hence, when I heard that this parent was building this happy device, I asked, "Well, aren't you concerned about hurting the kids?" He looked at me as if I were

something rather strange and said, "Well, don't you realize these kids right now are in restraints, they are hurting themselves, they are totally parasitic, but if we use this device, we might be able to make human beings our of them." Coming from the parent, you see, the concept of adversive conditioning was quite acceptable.

Parents are crucial in generalizing from the institution to the home. If we're really going to get some of these kids home, the parent must be a member of the team. There are some workers now who train the parent very carefully to train the child. It is relatively easy to train the parent to apply behavior shaping techniques to his child, and hence to facilitate generalization from the institution to the home. We all know that if operant techniques are not applied consistently, that if there is an intermittant type of reinforcement, that there might be an increase in undesirable behavior, and that it might become more resistant to extinction. As you know, we frequently complain that a kid who does beautifully in the institution regresses the moment you send him home. Frequently the reason stems from the fact that we have not trained the parent and hence he doesn't have a clue and may continue to reward undesirable behaviors. There are now some people who either bring the parent into the facility and train the parent with the child, using one-way mirrors and this kind of bit, or they go into the home, and watch the interaction between parent and child. The trainer may then say, "Wait a while, you're doing that wrong. You're not giving that child any attention, and he's sitting there being a good boy. Now's the time you should go up to him and say, "good boy." The parent might reply, "I can't

go over there and say 'good boy'." The trainer asks, "Why can't you?" and the parent says, "Cause I hate the little S.O.B.'s guts." Then the trainer says, "I don't care if you hate him, love him, or anything else -- you go over there and tell him he's a good boy." You notice the difference between the traditional psychoanalytic approach, dealing with ambivalences and all this, and the behavior shaping approach. So the parent goes to the child and says, "Good boy" and the trainer explains, "No, that's not the way you do it, you do it like this, 'Good boy'." The parent says, "Oh" and does it a little better, and the trainer says, "That's good - now you're doing it right -- here's an M & M for you."

Let me say a few words about the goals of administration. First, let me describe what I call "false goals." I'm sure these false goals are familiar to you, and they may well intrude in your day to day work. First of all, let me mention the goal of system maintenance: preserving the system. The rationale underlying this goal is that we cannot afford to change. For example, the administrator may argue, "Look at all the money that's already been invested in developing these buildings, we can't afford to tear these things down -- there has been too much invested already." And then, of course, there are all the personal vested interests -- "Look at all the people we've hired" -- and all these happy considerations. So a lot of the activities of the administrator may be directed to maintaining the present system.

Second, consider the goal of security, of self-preservation. Many administrators are vitally concerned with their own precious skins. There is danger in the unknown. To venture into the unknown is to become vulnerable, and administrators are often keenly concerned with minimizing their vulnerability.

Sometimes the administrator adopts the policy that it is better "to be safe than sorry." It's a play safe strategy. And remember that people are canned for sins of commission, for for sins of omission. This orientation leads to maintenance of the status quo, not trying anything new or different or risky.

A third false goal is the maintenance of homeostasis, a term borrowed from physiology. Homeostasis refers to a tenuous balance of power within the system. The administrator who devotes himself to the goal of maintaining homeostasis is a person who wants to minimize conflict. As I listened to one or two of you during the intermission, I heard you say, "Well, if we move into these new situations, we will develop a lot of interpersonal conflict. Conflict with department heads, and so on." Such an observation is very probably accurate. Any change the administration makes leads to a renewal of hostilities, for the institution exists in a state of cold war; any change made is likely to lead to conflict. So the administrator develops the "don't make waves" syndrome -- "Let's keep everything peaceful and quiet." On occasion I have heard my colleagues discussing their institutions when one of them might say, "Hey, I've got a good spot, there are no conflicts, everything's peaceful." That place must be "deadsville." And sometimes the administrator takes the step of guarding himself from the "ripple effect." The ripple effect refers to the situation where you introduce a new program, and you hope that this program will catalyze change throughout the entire system. The HIP projects were a good case in point. How many of you had HIP (Hospital Improvement Program) projects in your institution? A number of you. I

used to speak of the syndrome of "the HIP up on the hill." In some institutions, the HIP programs were circumscribed within a single building which, not infrequently, was physically isolated from the rest of the institution, to make very sure that this "demonstration" project would have no impact on the rest of the institution. If you phoned the main facility and asked to talk to Dr. Schnook, Director of the HIP project, you were supposed to hear, "We don't have a Dr. Schnook on our staff." Well, he's part of your HIP project." "Oh, the HIP project, well that's not our institution."

Finally, a few words about the goal of empire building, of self-aggrandisement, and I know you won't believe this, but a lot of administrators have this goal. The basic philosophy if that "it takes an empire to have an emperor." Many administrators yearn to be emperors, therefore, they have to build empires. And this leads to what I call "hypertrophy of the superstructure" or "management to oblivion" If you look at some state departments, you find massive bureaucracies -- bureaus of long range planning, bureaus of construction, bureaus of budgeting, bureaus of program analysis, and on and on, and on -- bureaucracies which look like a metastisizing cancer. And yet when you examine the living unit of the resident you see not one iota of impact. These superstructures lead to empires. And you're all familiar with Parkinson's Law, of course: you can keep adding people indefinitely, and they'll always find something to do to fill up the time. There are also the status symbols of the empire: the draperies, the rugs, the secretaries. Try and remove a secretary from someone sometime, it's easier to yank the ears off of an elephant (a most difficult task) for herein lies status, herein lies the empire.

Building the empire leads to proliferations of policies, manuals, procedures, and other guardians of the empire. Once these guardians are established, it becomes impossible to extracate the empire from the morass of red tape within which it has become firmly implanted. Of course, none of you engage in these management practices, but perhaps you will recognize them in some of your colleagues, some of your supervisors, or some of the other departments with which you must work.

Now let me say a few works about "legitimate" goals of the administrator. I shall discuss these in terms of the basic question: "Whom do we serve?" As I see it, we serve at least four masters, and these masters are not necessarily consistent with each other. First, there is society, which asks us to eliminate or to minimize deviancy. Society does not tolerate deviant behavior. So, we address ourselves to programs which either change the deviancy in the retarded, or remove the deviant from society. It is this latter approach which has lead to these magnificent institutions which we operate today. Our second master is economy -- we are asked to run programs efficiently. The bureau of the budget, the legislature, the governor's office -- the key distributors of the M & M's in this world -- will reward behavior that is aimed at efficiency. And now we're all adopting the happy PPBS system of budgeting, which requires that we demonstrate concrete results. We now justify budget requests by such statements as, "We plan to institute this program to toilet train profoundly retarded, which will save X number of pounds of laundry a year, which will mean X number of dollars saved." The administrator's third master is the family. Parents have a very strong impact on our programming. What does the family ask? The family asks us to humanize the retarded -- to shape their child

into their own image. And hence, we are mounting programs for the profoundly retarded to make the individual more like a human being. Sometimes I wonder how meaningful our activities are to the retarded themselves. For instance, I have observed programs for the severely or profoundly retarded and found that children at mealtime have to stand behind the table until everybody is standing, and then they "say grace," if you can imagine such a thing. That is they stand in a certain position and they make a sound of some type, and then they can sit down. I'm not sure that this is meaningful to these individuals, but it approximates the behavior of a human being.

Finally, there is a fourth master, the retarded himself -- and I fear that his soft voice is seldom heard, and yet we speak of self-determination. How many options do we give the retarded? How much opportunity does he have for choice? How actively does he participate in decisions that will shape his life? I fear that in most of our systems the answer is "no."

That concludes, you will be glad to hear,my formal presentation on "Resources for Implementing the Administrative Model." I have not addressed myself specifically to education, since I was not really asked to do this. However, perhaps I should say a word or two about education. I'm sure you have heard that the function of the educator in residential institutions is undergoing some change. Part of this change is due to a modification in population. As I understand it, the basic change in institutional population is towards a more severely and profoundly retarded.adult population. As a result, our favorite consumer of educational services -- i.e. the mildly retarded, the pseudo-retarded, or the culturally retarded --

will less and less be grist for our mill in the institutions. Instead we shall find ourselves more and more confronted with the severely retarded, the profoundly retarded, the multiply handicapped, the individual who is blind, deaf, has speech defects, or motor disturbances. As this change is taking place, we are beginning to redefine our population. The terms "sub-trainable" and "bedfast" are being dropped from our vocabulary. We are redefining our population optimistically so as to include everybody in the institution as having some potential for development. This is not new of course -- you will recognize that even during the later part of the last century there was the same feeling that everybody, including those then called the idiots, were capable of some development.

The development of techniques that are not dependent upon language, is, I think, opening the door to the educator, to work much more effectively with this segment of the population. Traditionally, as I understand it, we have operated largely in the area which requires language, or verbal communication. To embark upon an area in which we do not use language, or use it minimally, or use it unidirectionally, is a new challenge. We are also being impressed with the fact that, to make a significant change in the behavior of the severely handicapped, it is important to modify the total environment. So we no longer look at education and training as occuring in a classroom, between teacher and pupils, during 4 - 6 hours a day, for five days a week. This model is not applicable to the non-verbal retardate. Instead, we are beginning to think about the total environment in which he lives.

The educator has a particular opportunity to participate in this

shaping of the environment, for he is the expert in learning, and our premise is that the environment must be engineered to facilitate and stimulate learning. We're talking here about consistent behavior patterns on the part of all human beings that interact with the retardate, we're talking about a physical environment that will maximize sensory input, that will facilitate locomotion, that will facilitate manipulation of the environment, that will increase the meaningfulness of manipulations, and, yes, that will give the retardate some options for interacting with the environment. You are all familiar with Omar Khyyam Moore's model of the autotelic responsive environment. I think we are broadening this concept to apply to the life of the severely handicapped individual, for many of us feel that part of the tragedy of this individual is that he operates in a vacuum -- that his responses, though they are limited, are usually totally meaningless -- that is, there is no feedback from the environment. If we can begin to change this pathological interaction there is evidence that much of the behavior that we label as pathological would disappear. Sometimes, when you have nothing better to do, take a trip to a good zoo, and spend some time with the higher primates. They are immensely interesting and instructive animals. You will find that if, as unfortunately is usually the case, these animals are in a cage, with little to entertain them, they have developed many of the same behavior responses that we find in the profoundly retarded. They rock, they bang their heads, they pull their ears, they amuse themselves by waving their hands in front of their eyes, they drink their urine, they smear their feces and so forth. Yet, these are not, mind you, the responses that

you find in the natural habitats of these creatures. It is apparently a response to sensory-social deprivation. Let me suggest that much of the bizarre behavior observed in the profoundly retarded human may likewise be a function of an environment which is meaningless to him, for it fails to respond to his limited actions.

IX

An Administrative Model for the Residential Setting: An Application of Open System Theory

Dr. Arthur Lewis

The purpose of this paper is to suggest a model that may be useful in understanding the organization and administration of an educational program in a residential setting. In selecting such a model, certain assumptions were made regarding the nature of administration and education in residential settings. Administration may be thought of as functioning at three different levels. The first level involves an interpretation of rules and regulations. An intelligent clerk, armed with the latest edition of the rules, can administer at this level. The next level of administration extends beyond the application of rules and requires that judgments be made on cases that do not fit the rule book. The highest level of administration goes beyond the first two in that the administrator is the initiator of new policy based on his analysis of the operation of the system, its goals, and the society the system serves. The model selected should be of value to an administrator operating on this third level of administration in a residential setting.

In selecting a model it was assumed that education in a residential setting involves a complex series of interrelationships between individuals and sub-systems. It was further assumed that there is considerable interdependence between the residential setting and its environment. Thus a model will be useful to a policy level administrator as it enables him to gain insights into the complex interaction of the component elements of the organization and provides him with some perspective on the relationship of the organization to its environment.

Bureaucratic theory. One model considered was the bureaucratic form of organization which has influenced the administration of such diverse activities as running big corporations, operating schools, and managing the

affairs of government. The principles of bureaucracy were first stated by the German sociologist Max Weber. Working at a time when decision by tradition was the norm and when paternalism and nepotism were common, he sought a structure for organization that would overcome these conditions and be more rational in charcter. To achieve this goal, Weber enunciated certain organizational principles that comprised what he called an "ideal bureaucracy." A description of the characteristics of a bureaucracy as identified by Weber will reveal the extent to which bureaucracy guides our organizational lives:

1. "The regular activites are distributed in a fixed way as official duties."[1] This division of labor makes it possible to employ specialists for various positions and to hold them responsible for the performance of their duties.
2. "The organization of offices follows the principles of hierarchy; that is, each lower office is under the control and supervision of a higher one."[2]
3. "Operations are governed by consistent systems of abstract rules...(and) consist of the application of these rules to particular cases."[3] The use of such rules is to assure uniformity in the operation of an organization regardless of who occupies a particular position.
4. "The ideal official conducts his office...(in) a spirit of formalistic impersonality, without hatred or passion, and hence without affection or enthusiasm."[4]

5. "Employment in the bureaucratic organization is based on technical qualifications and is protected against arbitrary dismissal."[5]

Weber did not invent bureaucracy; there are evidences that it existed in ancient Egypt. However, he did develop a rationale for a bureaucracy and described its basic characteristics. He viewed bureaucracy as a way to maximize organizational efficiency. Weber stated,

> Experience tends universally to show that the purely bureaucratic type of administrative organization... is, from a purely technical point of view, capable of attaining the highest degree of efficiency...the fully developed bureaucratic mechanism compares with other organizations exactly as does the machine with non-mechanical modes of production.[6]

Note that Weber assumed that an effective organization was modeled after a machine. In arriving at this analogue he was following the predominant framework of thought used at that time, analysis. Through analysis an understanding of the functioning of any mechanism was gained by studying the functioning of each individual part. Thus, to understand how a machine works, it is necessary to analyze how each of its individual parts works. Conversely, once you know the specifications for a machine, you can construct it by assembling its constituent parts.

Weber assumed that social organizations could be analyzed and "assembled" in a similar fashion. Once you knew the purpose to be achieved by an organization you could design the parts needed to reach the objectives. To be able to assemble the parts required that tasks be specialized and performed in a standard way. To coordinate the various parts, it was necessary to provide for unity of command and some centralized decision-making procedures. It is easy to see how Weber developed his principles of a bureaucracy by using a machine as a model.

However, there are several evidences that bureaucratic theory, based as it is on a machine model, is becoming dysfunctional. In the first place, bureaucratic organizations are designed as efficient methods of achieving organizational goals. At one time the individual was viewed as a cog in a bureaucratic machine motivated only by economic gain. But, it is now recognized that the criteria of success in an organization must include the satisfaction of individual goals as well as organizational goals.

It is possible that through appropriate modifications the bureaucratic organization can provide at least some opportunities for employees to achieve their individual goals. However, the second problem inherent in a bureaucratic organization, inability to adapt to a changing environment, may be more difficult to resolve. Educational institutions are located at the focal point of change in a society in rapid transition; not only must they respond to changes in their environment, but increasingly, they are viewed as instruments of change. Bureaucratic structures are well designed to provide for the accomplishment of routine tasks. But increasingly the environment is unstable and changing and the need is for modes of organization which facilitate rapid adaptation to change. Warren Bennis forecasts, "It is the requirement of adaptability to the environment which leads to the predicted demise of bureaucracy and to the collapse of management as we know it now."[7]

Clearly an alternative to bureaucratic theory based as it is on a machine model is needed as a rationale for organizing educational programs in a residential setting. To be sure, the vestiges of bureaucracy will be with us for some time, but new bases for organization will emerge. A major assumption of this paper is that open system theory may provide desirable guidelines for the development of an effective organization.

Open system theory. One of the chief differences between bureaucratic theory and open system theory is the model which is used in deriving the theory. Through the use of open system theory an attempt is made to view an organization as a whole rather than to analyze its parts. To achieve this, open system theory is based on an organism as a model rather than on a machine as is the case with bureaucratic theory. That is, open system theory is organic in nature whereas bureaucracy is mechanistic.

The organization and the organism are more than analogues, they are both varieties of something more general. Anatal Rapoport and William Horvath point out, "There is some sense in considering a real organization as an organism, that is, there is reason to believe that this comparison need not be a sterile metaphorical analogy...Quasibiological functions are demonstrable in organizations. They maintain themselves; they grow; they sometimes reproduce; they respond to stresses; they age, and they die."[8]

There are of course differences between organisms and organizations that need to be recognized. Biological organisms have physical boundaries that are not present in organizations. When an organism dies a structure remains; when an organization dies, that is, ceases to function, there is no identifiable structure. The structure of an organism composed of its physical parts has no parallel in an organization. Structure in an organization is evident only as the organization functions.

Nevertheless, whether the model that is used is a machine or an organism will make a difference in the principles derived. For example, a pervasive problem facing organizations is that of change. If change is approached from a mechanistic point of view an attempt is made to modify

the actions and interactions of persons in the organization in accord with a new set of specifications. However, if an organic point of view is taken, the organization would be seen as a dynamic, learning, and growing entity. Change is then to be viewed in terms of development, or regression. And just as a healthy organism will develop and grow a "healthy" organization will be adaptive rather than maladaptive.

The adjective open has special significance in the term open system. Systems may be broken into two large categories, closed systems and open systems. Closed systems are isolated from their environment, no substances enter or leave the system; closed systems are most often found in the physical sciences. For example, a mixture of gases in a sealed container would be a closed system. Living organisms, however, cannot survive if they are shut off from their environment; they must secure some form of energy in order to live. For this reason organisms are open systems. Similarly, human organizations must be open to their environment in order to exist. Consider the many inputs into a residential setting. Without such inputs as pupils, teachers, administrative staff, service personnel, facilities, and instructional materials the organization would not continue to exist. Therefore, a residential setting is an open system. It is a complex of elements united into a whole by virtue of the interdependence of its elements and its existence depends upon an interchange of energy with its environment.

On the other hand, a mechanistic system is relatively closed. It is assumed that the structure is self-contained, and isolated from its environment. Thus the structure could be static as in a machine. Utilizing a machine model as a basis for organizing a residential setting is applying the static structure of a closed system to an organization that is acutely dependent upon its external environment for survival and which must, therefore, be treated as an open system.

A system may be defined as a complex of elements united into a whole by virtue of the interdependence of the elements. From this definition of system it becomed apparent that most systems contain sub-systems and are themselves sub-systems of larger systems. Thus several sub-systems compose a residential setting. For example, sub-systems such as those concerned with formal education, health and psychological services, and maintenance of the plant could be identified. At the same time the organization may be a sub-system of the educational system of the state. For purposes of this analysis, the total organization in the residential setting will be viewed as an open system based on an organic model.

Some understanding of an open system can be gained by examining eight characteristics of such a system as described by Katz and Kahn.[9] An attempt will be made to show the relationship of each characteristic to organizations in a residential setting.

1. Importation of energy. This characteristic follows from the the definition of an open system--there is some exchange of energy with the surrounding environment. In the case of a residential setting, there are many forms of energy that must be imported including professional and non-professional staff, physical facilities, food, and pupils. (If you have forgotten that pupils are a form of energy, you have been away from home too long.)
2. The through-put. An open system takes the energy it receives from the environment and transforms it in some fashion. This could be the production of an article or the performance of some service such as the education of a child. In the case of a residential setting the

transformation might be helping children to gain the understandings, skills, attitudes, and appreciations that will enable them to function effectively in society.

3. The output. Open systems, in exchange for the energy they have received, export some product into the environment. The output from a residential setting may be the child referred to above. Is there an output if the purpose of the residential setting is custodial care? Yes, the satisfactory provision of such a service to society does represent an output.

4. Systems as cycles of events. The pattern of activities of the energy exchange has a cyclic pattern. Thus pupils who leave the residential setting and find employment, become taxpayers and, in turn, help to provide additional inputs to the residential setting.

5. Information input and negative feedback. One important energy input into a system is information. This input informs the system about its environment and about its own functioning in relation to the environment. One pervasive problem facing all organizations is the necessity to respond to changes in the environment. A first step in responding is to have accurate information regarding the environment. It is particularly important for organizations in residential settings, dependent as they are on external resources, to have well established channels for information input.

Negative feedback is a special type of information input. The concept of negative feedback comes from Norbert Wiener's work in cybernetics. Negative feedback is an information input that results from energy expended by a system and that enables a system to modify its behavior in such a way that it can achieve its goals. For example, automatic pilot landing systems operate

by transmitting radio signals from the plane and having them returned again. The teacher who develops a way to periodically secure achievement test scores as a basis for planning learning experiences with children is applying negative feedback.

6. The steady state and dynamic homeostasis. Open systems, whether organisms or organizations, are able to maintain themselves through the importation of energy. However, it is not just maintenance at the same level--but maintenance with growth. Hence an open system is characterized by dynamic--not static--homeostasis. It is clear that adaptation to changes in the environment, made possible, in part, by information input, represents homeostasis. An open system that fails to adapt to changes in the environment will eventually be denied energy from the environment and will die. Clearly organizations in residential settings must be very attuned to changes in their environment and adapt to these changes in such a way that they grow and develop.

7. Differentiation. Open systems move in the direction of differentiation and elaboration. Functions of members of the organization become more specialized. Those of you who work in residential settings witness increased specialization among your colleagues. In the United States today medical specialists outnumber general practitioners.

8. Equifinality. This principle states that an open system can reach the same final state from differing initial conditions and by a variety of paths. In a mechanistic system the same initial conditions must lead to the same final result. Applying this characteristic to a school within a residential setting suggests there may be many different ways to organize the school and still achieve comparable results. This isn't to suggest that one way may not be better than another. But, in the

complexity of a school organization it is the interaction of many factors that makes for success or failure.

An application of open system theory. This paper proposes that an appropriate analogue or model for a residential setting is an organism rather than a machine. Thus an administrative model for a residential setting is to be derived from an application of open system theory rather than bureaucratic theory. Administrative models derived from bureaucratic theory describe relationships between parts and can be portrayed by lines on charts similar to blueprints of machines because it is assumed that the organization is static. However, the dynamic nature of open systems necessitates that administrative models be described in terms of the interaction of sub-systems as the organization functions. Such an administrative model cannot be visually portrayed; however, it can be understood as various processes such as innovation, decision-making, and evaluation are described. To demonstrate how open system theory can lead to the development of an administrative model, a design for evaluation of a residential setting will be described. The design will be based on the answers to certain questions. Answers derived from open system theory as well as typical answers will be given to show contrast.

Question 1: What is the purpose of evaluation?

Typical response: The purpose of evaluation is to determine whether or not the organization is achieving its goals. Open system theory response: The purpose of evaluation is to help the organization to maintain dynamic homeostasis, that is to enable the system to maintain itself and continue to grow. Evaluation becomes a source of information to be used in decision making.

Question 2: What do we evaluate?

Typical response: The product, that is the results of the work of the residential setting.

Open system theory response: All aspects of the system including the various sub-systems and their interrelationships. There are two reasons why evaluation of products only is inadequate. Business has found that by evaluating only the product, the quality of the operation may deteriorate even though the product evaluation is satisfactory. Of course, poor operating procedures eventually cause a decline in quality and/or quantity of the product. A second reason for evaluating more than the results is that there is a great waste of time if a system is not aware of mal-performance until 2 or 3 years later. If faulty concepts introduced in the fifth grade cause pupils to fail in an 8th grade arithmetic course, considerable time has been wasted--time that cannot be replaced as far as the children are concerned.

Question 3: When do we evaluate?

Typical response: Periodically, perhaps at the end of each year, maybe biennially. Open system theory response: Evaluation should be a continuous process. The organization needs an on-going monitoring system in order to identify problems as they first develop. It is on the basis of this information that the decision makers are able to modify the day-by-day operation, the organizational relationships of individuals and sub-systems, and the goals of the organization.

Question 4: What criteria should be used in evaluation?

Typical response: The goals of the organization should be used as a source of criteria for evaluation.

Open system theory response: In addition to the organizational goals,

the goals for various sub-systems should provide criteria for evaluation. Criteria should also be developed to monitor the interface relationships of the various sub-systems.

Questions 5: Who should make the evaluation?

Typical response: Some outside agency, possibly a university or a state department of education.

Open system theory response: Those who will use the information gained from the evaluation should either conduct the on-going evaluation or have immediate access to the results. An external agency might be engaged to conduct a periodic audit of the organization.

From the responses to the preceding questions, it is clear that an evaluation design should provide for a steady flow of information to the decision-makers. In the case of a residential setting, this might well be the Superintendent and his immediate staff.

It is possible to have an information overload and thus to miss important signals. It is said that monitors on duty at Pearl Harbor received information that should have made them realize that an air attack was imminent but that it was buried in the avalanch of other routine information. There needs to be a way to have immediate access to information that warns of impending crisis. The building custodian is warned by an alarm when the pressure is building up to the danger point in the boilers. The director of education has no such warning when pressure is building up to the danger point in Miss Jones' classroom.

The evaluation design should provide for the continuous monitoring of the inputs into the residential setting. This would include a consideration of the staff, their qualifications and competencies and what they were doing to improve their skills. There should be a monitoring of the children as inputs.

What procedures are used in the selection and assignment of children? Are the diagnostic instruments used sufficiently predictive? Are you surprised at the way some children perform when they finally arrive at the residential setting? Is the nature of children you are serving changing? Do you have a way to monitor this so you can control the nature of your institution, or do you suddenly wake up some morning and realize that over a span of a few years the nature of children you serve has changed? Provision should also be made for a continuous monitoring of such in-puts as the physical facilities, the health and psychological services for the children, the curriculum in the school, and the instructional material used.

The evaluation design should include procedures for monitoring the through-put function of the residential setting. One characteristic of the residential setting that should be capitalized on is the fact that the entire experience of the child can be a planned educational experience. (All experiences of children in any setting may be educational, but often they do not reinforce each other.) To make certain that the residential setting is capitalizing on this opportunity, provision should be made to monitor the total impact of the residential setting on the child--not just the impact of the formal education sub-system.

In designing an evaluation of the through-put, provision should be made to monitor the various sub-systems such as formal education, maintenance, and service. Sub-systems should be monitored, not only in terms of their own goals, but in terms of the goals of the organization. It is easy for sub-system goals to displace the goals of the organization. For example, the custodial crew may insist that children stay off the grass in order to improve the beauty of the grounds. Having beautiful grounds may not be a goal of the larger system.

Certain conditions are necessary for a synergetic organization--one where the various parts are working together in coordination. One condition for synergy is general understanding and acceptance of the goals of the organization; another is easy communication across the boundaries of the various sub-systems. The evaluation design should provide a way to monitor the extent to which these conditions are being met.

The evaluation design should also provide a way to monitor the out-put in relation to the goals of the residential setting. In most instances these goals will be translated into expectations for individual children. This will require frequent goal-setting for individual children and evaluating the extent to which individual children achieve these goals. Thus monitoring of the out-put is a continuous process as goals are set for and with children, as they achieve these goals, and as new goals are sought. Nor does the evaluation stop when the child leaves the residential setting; there should be periodic follow-up on his progress in the community. If there is a sub-system responsible for vocational guidance, placement, and follow-up, their effectiveness can be evaluated in these terms.

A final element of the evaluation design should be an assessment of the effectiveness of communication channels external to the residential setting. The importance of receiving and sending accurate messages to parent groups, legislative bodies, and boards of directors cannot be overemphasized. The evaluation design should provide a way to monitor the flow of information to these key groups. Informal communication is also important. An evaluation design should be able to monitor the extent to which students and staff are participating in community activities.

The application of open system theory in designing an evaluation system demonstrates how an administrative model can be developed. Such a model will

be useful to an administrator as it provides fresh insights into the nature of an organization and aids him in solving problems. If you are looking for a way to synthesize your knowledge about your residential setting and gain new perspectives on your work, a model based on open system theory may serve you well.

FOOTNOTES

1. Peter M. Blau, Bureaucracy in Modern Society. New York: Random House, 1956, p. 28.)

2. Ibid., p. 29.

3. Ibid., p. 29.

4. Ibid., p. 30.

5. Ibid., p. 30.

6. Ibid., p. 31.

7. Warren G. Bennis, Changing Organizations. New York: McGraw Hill Co., 1966, p. 10.

8. Anatal Rapoport and William J. Horvath, "Thoughts on Organization Theory," in Buckley (ed.), Modern Systems Research for the Behavorial Scientist. Chicago: Aldine Publishing Company, 1968, p. 75.

9. Daniel Katz and Robert L. Kahn, The Social Psychology of Organizations. New York: John Wiley and Sons, 1967.

Appendix A

Summary of Group Problems

The problems of the group can be analyzed by attempting to categorize them into some schemata. The number of times a problem was mentioned was not tallied; what concerns us here are the problems being seen at your particular institution.

It does not take an extensive amount of time in mental retardation to realize that staffing would be mentioned as a critical area. Recruitment of qualified staff is difficult due to salaries, working conditions and over-crowded classrooms. The problems of motivating a staff which is determined to produce minimally, or a staff which recognizes the strength of tenure were also raised. When these problems are compounded by a lack of coordinated leadership or an inadequate definition of personnel responsibility, an undefined program can only result.

The institution's educational programs also suffer from being directly subordinated to medical officers. The diffciulties of coordinating learning experiences between the teacher (education department) and the attendant (nursing department) are extreme and often lead to hostility between departments.

This, of course, leads to communication problems, a third major emphasis of the group. Methods for developing a worthwhile orientation program, for inservice programing and for utilizing consultant staff are needed. Mechanics for involving personnel in the team approach have also been requested. The gaps of information between departments, between institutions and between institutions and their central offices was also seen as an area of concern. The community's misinformation rather than lack of information about residential centers can be seen as a stumbling block in returning residents to the community. Closer relationships with

home communities and the local facilities or agencies is of extreme importance.

The financial problems of institutions should also be analyzed. Methods of obtaining funds, other than Title I monies, need to be explored. Problems of allocating funds for purchasing materials, etc. need to be discussed. How should personnel, facilities and materials best be used? What can be done about overcrowding, about the isolation of the institution from populated areas?

The lack of clearly defined goals for the profoundly retarded inhibits effective programming. The danger of the 'self-fulfilling prophecy', especially with this group, should be looked at. With the other levels of residents, the lack of social adjustment training prevents successful employment outside the institution. Work-study programs which are unable to offer some financial rewards are not adequately preparing the resident for the larger community. Half-way houses need to be defined more clearly. Questions of size, staff, legal implications, financing and programming must be answered. Throughout the entire area of programming the problem of evaluation is paramount. The need for effective evaluation tools for all programs is evident. The direction of programming must also consider the quantitative or qualitative role of the educational staff. Then too, analysis must be made of the age limitations imposed on those to be educated.

It is hoped that these problems can help define the direction of the institute; the answers can assist the field to move in a positive direction.

Appendix B

Reactions to Problem Solving

Problems for Simulation Session # I

Prepared by Mr. Harvey Stevens

1. The Superintendent is interested in developing programs which will be directed towards helping Nursing Care and Cottage Life personnel actively carry out a meaningful program which will (1) develop readiness for school for the young child and (2) help re-enforce concepts learned in the classroom. Identify the elements of such a program and describe how you would implement it.

2. Consideration is being given by the Superintendent to using teacher aides or teacher assistants in selected classrooms and for selected teachers. Delineate the problems you would envision being encountered in implementing such a program.

3. The In-Service Training Department has indicated that they can make available several hours in the revised aide training program to the education department. It was suggested consideration be given to including discussion relating to (1) role of education in training of the mentally retarded and (2) developing knowledge and skills to help education achieve its goals, e.g., helping re-enforce classroom learning. Describe how this might be accomplished.

4. The institution staff needs to continuously maintain contact with the community in order to maintain and increase its visibility. The educator also has a need to increase his sphere of influence. What activities might the educator in a residential setting undertake to increase his visibility (1) with a nearby university/college, (2) participating in local and state professional educational associations, (3) participating in local and state ARCs, (4) etc.

5. You have been requested to evaluate your academic program for the older educable mentally retarded. What factors might be considered in delineating an evaluation of this program.

6. Your Superintendent has requested that you develop a new salary schedule for your teachers. What factors would you take into account in developing a realistic salary schedule.

7. You decide that it would be helpful to have specialists from other disciplines--P.T., O.T., and Speech and Hearing--to come into the classroom and help the teacher in creating a more favorable learning environment for the multiple handicapped child. Your teachers are resistive. What might be done to overcome their resistance and utilize this extra help? How might you deal with the teacher who threatens to quit if one of them "dares enter my classroom"?

8. You have a Title I project which will enable you to employ an additional teacher. You are having difficulty locating a qualified teachers. You have found two women who are qualified but each one only work half time. You have located one whose credentials and references are below average. What might you do? Why would you?

July 2, 1969

Mr. Harvey A. Stevens, Chairman
Mr. Carl A. King, Recorder

Summary of Group I's Discussions re: Problems for Simulation Session #1

Introduction: The processes employed by the group were at first diffuse and then began to resemble the sequence of those involved in problem solving. The only resources available to the participants were their own personal experiences and the literature they read. When cued to personal experience, the recounting of these was self-propelling and often away from the target or problem. Finally, the group realized the necessity for defining terms and problems before solutions could be sought.

The priority of the problems reviewed was in the following order: #2, #3, #6 and #5.

Problem #2 - Problems encountered in the utilization of teacher aides and teacher assistants.

The group identified the following problems:

1. Personality factors of the teacher may prevent her from working effectively with another adult. An insecure teacher would feel that he or she were constantly being evaluated.
2. The inability of the teacher to clearly define an assignment of tasks for the teacher aides or assistants would make the assistants insecure.
3. An aide or assistant with a strong personality may polarize the situation by coying for the residents' attention.
4. A superintendent may abuse such an arrangement by overloading the classes.

It was suggested that some of these problems may be averted by developing an inventory of tasks performed by the teacher. These tasks should be categorized so that professional, semi-professional and non-professional tasks are clearly defined. Opportunities should be provided for cooperative planning by the teacher and the assistants and/or aides.

Problem #3 - Revised aide training program to involve the education department.

The group felt that institutions should explain the importance of the role of the education program in the growth and development of the residents. Teachers and aides should meet together to clearly define the objectives. Each group should visit and observe the others at work so that teachers would know what problems aides are encountering and aides will know what teachers are doing. The in-service training should be conducted on a group basis and on an individual basis.

Problem #6 - Factors to be considered in developing a realistic salary schedule.

The group felt that they would like to gather the following information before suggesting a new salary schedule:

1. Review salaries for teachers in comparable positions in public schools.
2. Gear salary schedule to level of preparation of the individual.
3. Relate compensation to length of work week and work year.
4. Delineate the fringe benefits and their costs.
5. Utilize the "barrier concept" - increased compensation for advanced education and training.
6. Provide compensation for prior experience.
7. Relate compensation to performance (merit rating).

Problem #5 - Factors to be considered in delineating an evaluation of the academic program for the older mentally retarded.

The group felt that the need to define "academic program". It was stated

that this should consist of whatever could be measured by an achievement test. At this point some in the group stated that we ought to review our philosophy of education for the older mentally retarded. If we utilize achievement tests to a great degree, we are bound by normative values and in a sense will be guided by them in developing a program. In effect, we will be pouring individuals into an educational mold. On the other hand, if we focus on the need of the the individual we will focus on behavioral objectives and begin to identify a whole series of functional tasks in which the individual will have to show competence. The focus here is on the curriculum and if the individual has not achieved competence, the curriculum will have to be altered until he does.

Our chairman, Mr. Harvey Stevens, in commenting on the process utilized by the group in dealing with problems suggested that the following approaches be used in problem solving:

-A-

1. Define the problem.
2. Gather the facts.
3. Identify alternate solutions.
4. Select one solution.
5. Implement the selected solution.
6. Evaluate the outcomes.
7. Make recommendations: 1) Discontinue
   2) Modify
   3) Continue

-B-

1. State the question.
2. Provide the facts.
3. Arguments for.
4. Arguments against.
5. Conclusion.
6. Recommendations.

Simulation Group II

Mr. David Rosen, Chairman
Nickie Berson, Recorder

Question #3

In-Service -(definition)- institutional program for training personnel, historically originating from federal grants for attendant training, now extended to all staff members from non-skilled to professional. Can be directed by leaders from any of the professional disciplines, or someone with industrial or personnel background.

Assumption: that the In-Service Department is good.

Primary Goal: revise traditional concept of education interms of classroom, blackboards, etc., and instill new concept of "education" for the Level I resident.

Specific Goals for In Service Program:

1) Program should include training by and for all personnel: recreation, therapy, etc.
2) Special education teachers who aren't trained for the profoundly retarded must see their role changed or altered to include this group.

3) In-Service should program, but attendants should implement training.
4) The aide must see where he is going. He must feel a status. He is not on loan to the education department, but occupies a specific position.
5) There should be less verbal, more affective teaching.
6) In-service must evaluate as well as teach. Evaluation begins before programming and must be continuous until end. Identification of problems must be referred to proper official who is in a position to effect change.
7) In-service should be concerned with orientation, from a 2-3 day overall new employee orientation to a 2 or 3 month intensive specific orientation to a job assignment.
8) In-service can be effective in specific lessons - spotlighted on specific groups for immediate concerns such as safety, emergency procedures and communication or personnel problems.
9) In-service is a continuous program, from orientation to resignation or retirement.

Question #5
Assumption of Group: There is no academic program per se for older E.M.R.
Definitions:
Academic instruction is the formal learning that is integrated or "personalized" into the vocational or adult educational program.
Who Evaluates?
Must be a composite group including pre-vocational and vocational teachers, vocational counselor, job supervisor and social worker.
What Tools of Evaluation?
Objective tests, checklists, work rating charts, personal observations.
Specific Factors
1. Begin assessment before placement and continually reevaluate to see if placement is appropriate.
2. Evaluate entire curriculum for continuity.
3. Use community as a classroom. Evaluate community attitudes. Does it offer sufficient experiences. Has learning transferred to community?

Simulation Group III

Mr. Robert Smilovitz, Chairman
Mr. William Vogel, Recorder

Problem #5 - Reevaluate academic program for older educable mentally retarded.
1. Evaluations should not be "one shot" affairs; evaluations should be continual.
2. Evaluations should be of needs of students and evaluations of the programs.
3. Evaluations should lend themselves to computer indexing, which also contains resident history and former programs.
4. Evaluations as controlled studies have little merit; institutional processes have too many built-in variables which invalidate the studies.

Problem #3 - In-service training program.
1. The concept of the aide must be changed so personnel will not differentiate to the extent of stigmatizing.
2. Training should be patterned more after the Public Health nursing approach instead of the more traditional medical style.
3. Content of the in-service program should include not only bases and

principles, but also experience in specific situations, e.g. in the ward.

4. In-service training should be continual because training is designed to meet needs which are continually changing.
5. In-service training has value for even the seasoned professional. Trainees can offer insights as yet unrecognized.

Problems for Simulation Session # II

Prepared by Mr. Harvey Stevens

1. You receive an anonymous letter which states that one of your teachers is "stealing my husband". You are requested to tell the teacher she should "stop seeing him". What would you do? Why?

2. One of your teachers is continually reporting 15 to 20 minutes late each day. You have politely cautioned her about the need to be on time. She respectfully reminds you that "some of the social workers, psychologists and physicians are coming late". How would you handle the situation?

3. Several staff members outside your department have commented upon the "odor of alcohol" on the breath of one of your teachers. What would you (1) tell these staff members, (2) discuss with the teacher? Why?

4. You have a teacher vacancy. You have been asked by a very loyal employee to accept his daughter who was recently released from a mental hospital. This fact is know throughout the institution. She has had several courses in mental retardation but is not fully qualified. What would you do?

5. You state laws forbid electioneering while "on the grounds". It also prohibits distributing "hand bills", etc. One of your employees is doing this during her lunch hour. You caution her. She maintains that "what I do on my lunch hour is my business". She continues this practice. What action should you take?

6. A very loyal, long-term teacher was observed hitting a student. Marks, in the form of bruises, were noted later. This was reported to you. What action do you need to take? What additional information do you need to help you make a decision?

7. Mrs. Jones has been an above average teacher on your staff for more than five years. Recently she has shown evidence of being extremely fatigued. She has seen her physician. He calls you and informs you, confidentially, that Mrs. Jones has a terminal condition, that she can continue to work but should be given a "free period" in mid-morning and a "free period" in mid-afternoon. What should you, what can you, do?

Appendix III

List of Conference Participants

Connecticut

Mr. Earl L. Long
Office of Mental Retardation
Department of Health
Hartford, Connecticut

Mr. Edward D. Wilkinson
Mansfield State Training School
P.O. Box 51
Mansfield Depot, Connecticut 06251

Maine

Mr. Arthur J. Banister
529 Mitchell Road
Cape Elizabeth, Maine 04107

Pineland Hospital and Training Center
Box C, Pownal, Maine 04069

Mr. Bruce P. Libby
Pine Drive
Gray, Maine

Pineland Hospital and Training Center
Box C, Pownal, Maine 04069

Massachusetts

Sister Edmund, O.S.F.
Saint Coletta School
Hanover, Massachusetts 02339

Mr. Emmett B. Finck
42 Oak Street
Plymouth, Massachusetts

Saint Coletta School
Old Washington St., Hanover, Massachusetts

Mr. Robert J. O'Keefe
Paul A. Dever State School
Box 631
Taunton, Massachusetts 02780

Sister Rebecca, O.S.F.
Saint Coletta School
Hanover, Massachusetts 02339

Dr. William J. Strong
459 Britton Street
Raynham, Massachusetts 02767

New Hampshire

Mr. Hollis J. Eaves
Center Harbor P.O.
New Hampshire 03226

Laconia State School
Laconia, New Hampshire

New Jersey

Mrs. Bryna Berson
18 Michael Street
Fords, New Jersey

Mr. Albert DeWitt Gray, Jr.
140 State Street
Hackensack, New Jersey

Essex County Youth House
Newark, New Jersey

Mr. Charles Magill
100 North Lakeside Drive East
Birchwood Lake, Medford, New Jersey

New Lisbon State School
New Lisbon, New Jersey

New York

Mr. George Bracy
Cascade Road
Amenia, New York 12501

Wassaic State School
Wassaic, New York 12592

Mr. Edward Jennings
209 Grace Avenue
Newark, New York

Newark State School
Newark, New York 14513

Miss Judith Radell
Sunmount State School
Tupper Lake, New York 12986

Dr. Carl H. King
2190 Boston Road
Bronx, New York 10462

Mr. Joseph H. Searow
207 North George Street
Rome, New York 13440

Rome State School
Rome, New York 13440

Miss Edythe K. Van Antwerp
26 Davison Lane West
West Islip, New York 11795

Suffolk State School
Melville, New York 11746

Pennsylvania

Mrs. Lillian F. Cole
241 West Saylor Street
Atlas, Pennsylvania 17851

Selinsgrove State School and Hospital
Box 500 Selinsgrove, Pennsylvania

Mrs. Janie J. Pratt
5946 Cobbs Creek Parkway
Philadelphia, Pennsylvania

Edward R. Johnstone Training & Resear
Bordentown, New Jersey 08505

Mr. John Sonessa
1832 Moore Street
Philadelphia, Pennsylvania

Woods School
Langhorne, Pennsylvania

William A. Vogel
816 Valley View Apartments
Allentown, Pennsylvania

Hamburg State School and Hospital
Hamburg, Pennsylvania

Mr. Harry L. Watkins
82 Second Avenue
Franklin, Pennsylvania

Polk State School and Hospital
Polk, Pennsylvania 16342

Mr. Vernon Wilder
P.O. Box 211
Cresson, Pennsylvania

Cresson State School and Hospital
Cresson, Pennsylvania

Rhode Island

Mr. Peter DeMasi
40 Barbara Ann Drive
North Providence, Rhode Island 02911

Zambrano Memorial Hospital
Wallum Lake, Rhode Island 02884

Mr. Walter A. King
Box 9
North Kingstown, Rhode Island

Dr. Joseph H. Ladd School
P.O. Box 9, North Kingstown, Rhode Island

Mr. Alvin F. Rubin
Dr. Joseph H. Ladd School
P.O. Box 9
North Kingstown, Rhode Island